MEDICARE AND MEDICAID REFORM: PROTECTING THE AGED AND INDIGENT IN TEXAS

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

JULY 2, 1985, EL PASO, TX

Printed for the use of the Select Committee on Aging

Comm. Pub. No. 99-532

U.S. GOVERNMENT PRINTING OFFICE

52-820 O WASHINGTON : 1985

H141-12

SELECT COMMITTEE ON AGING

EDWARD R. ROYBAL, California, *Chairman*

CLAUDE PEPPER, Florida
MARIO BIAGGI, New York
DON BONKER, Washington
THOMAS J. DOWNEY, New York
JAMES J. FLORIO, New Jersey
HAROLD E. FORD, Tennessee
WILLIAM J. HUGHES, New Jersey
MARILYN LLOYD, Tennessee
STAN LUNDINE, New York
MARY ROSE OAKAR, Ohio
THOMAS A. LUKEN, Ohio
BEVERLY B. BYRON, Maryland
DAN MICA, Florida
HENRY A. WAXMAN, California
MIKE SYNAR, Oklahoma
BUTLER DERRICK, South Carolina
BRUCE F. VENTO, Minnesota
BARNEY FRANK, Massachusetts
TOM LANTOS, California
RON WYDEN, Oregon
GEO. W. CROCKETT, JR., Michigan
WILLIAM HILL BONER, Tennessee
IKE SKELTON, Missouri
DENNIS M. HERTEL, Michigan
ROBERT A. BORSKI, Pennsylvania
FREDERICK C. BOUCHER, Virginia
BEN ERDREICH, Alabama
BUDDY MacKAY, Florida
HARRY M. REID, Nevada
NORMAN SISISKY, Virginia
ROBERT E. WISE, JR., West Virginia
BILL RICHARDSON, New Mexico
HAROLD L VOLKMER, Missouri
BART GORDON, Tennessee
THOMAS J. MANTON, New York
TOMMY F. ROBINSON, Arkansas
RICHARD H. STALLINGS, Idaho

MATTHEW J. RINALDO, New Jersey,
Ranking Minority Member
JOHN PAUL HAMMERSCHMIDT, Arkansas
RALPH REGULA, Ohio
NORMAN D. SHUMWAY, California
OLYMPIA J. SNOWE, Maine
JAMES M. JEFFORDS, Vermont
THOMAS J. TAUKE, Iowa
GEORGE C. WORTLEY, New York
JIM COURTER, New Jersey
CLAUDINE SCHNEIDER, Rhode Island
THOMAS J. RIDGE, Pennsylvania
JOHN McCAIN, Arizona
GEORGE W. GEKAS, Pennsylvania
MARK D. SILJANDER, Michigan
CHRISTOPHER H. SMITH, New Jersey
SHERWOOD L. BOEHLERT, New York
JIM SAXTON, New Jersey
HELEN DELICH BENTLEY, Maryland
JIM LIGHTFOOT, Iowa
HARRIS W. FAWELL, Illinois
JAN MEYERS, Kansas
BEN BLAZ, Guam
PATRICK L. SWINDALL, Georgia
PAUL B. HENRY, Michigan
JIM KOLBE, Arizona
BILL SCHUETTE, Michigan

FERNANDO TORRES-GIL, *Staff Director*
PAUL SCHLEGEL, *Minority Staff Director*

CONTENTS

Members Opening Statements

	Page
Chairman Mike Synar	1
Tommy F. Robinson	3
Ronald D. Coleman	4

Chronological List of Witnesses

Hon. Nancy McDonald, State representative, Texas House of Representatives	5
Hon. Jack Vowell, State representative, Texas House of Representatives	15
Helen F. Bogas, senior citizen, El Paso, TX	21
John A. Danley, member, Texas State Legislative Committee, American Association of Retired Persons, El Paso, TX	22
Margarita Giron-Sanchez, cochair, El Paso Interreligious Sponsoring Organization	31
Sister Blandin Murphy, El Paso Interreligious Sponsoring Organization	32
Bill Kennedy, administrator, R.E. Thomason General Hospital, El Paso, TX	32
Mary Polk, executive assistant, Texas Department of Human Resources	42

Appendix

Additional material received for the record:	
Jack H. Smith, assistant State director, American Association of Retired Persons, letter and attachments	49

MEDICARE AND MEDICAID REFORM: PROTECTING THE AGED AND INDIGENT IN TEXAS

TUESDAY, JULY 2, 1985

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
El Paso, TX.

The committee met, pursuant to notice, at 2:57 p.m., in the El Paso City Council Chamber, City Hall, El Paso, TX, Hon. Mike Synar (acting chairman of the committee) presiding.

Members present: Representatives Synar, Robinson, and Ronald D. Coleman.

Staff present: Christinia Mendosa, professional staff, Select Committee on Aging; Nancy Padilla, legislative assistant, Norma Fierra, district assistant, and Lucy Calderon, district assistant, of Representative Coleman's staff.

OPENING STATEMENT OF CHAIRMAN MIKE SYNAR

Mr. SYNAR. The House Select Committee on Aging will come to order.

Welcome, ladies and gentleman.

I am Congressman Mike Synar from Muskogee, OK, and I am glad to be here today. I will be serving as the chairman of the Task Force on the Rural Elderly and the committee during today's hearing.

It is a pleasure to be in El Paso again. I have been here on a number of occasions, and I am particularly pleased because we are here with our good friend, Congressman Ron Coleman.

Today the House Select Committee on Aging is holding a hearing to examine several proposals for reforming Medicare and Medicaid, or for replacing Medicare and Medicaid with a more comprehensive health insurance program.

I want you to know that the future of health care for the elderly is a top priority the House Select Committee on Aging. Throughout this year we will be holding hearings in Washington and field hearings throughout this country to learn how to ensure better quality health care for the poor and the elderly.

As you well know, many different proposals have surfaced in recent years to reform the Medicare and Medicaid Programs.

In earlier years, we saw proposals which focused on improving access and quality for the Nation's poor and elderly. However, times have certainly changed. Today's proposals tend to ignore the health needs of the people of this Nation. They focus solely on cost

containment, only for the purpose of rescuing the Medicare and Medicaid Programs.

I agree wholeheartedly that we must maintain the viability of Medicare and Medicaid. I certainly agree that we must increase efficiency in health care delivery assistance. We must reduce fraud and abuse by health care providers. We must limit unnecessary, diagnostic procedures, use less of hospital and nursing homes, and lower charges for health care service.

However, I am becoming gravely concerned that many cost-containment strategies hurt our elderly, and take away the health care gains we have made in the last 20 years.

This committee has already received reports that Medicare's new perspective payment system, the DRG's, for hospitals is resulting in poor quality care being given to our elderly.

In some cases, senior citizens are being released from hospitals too early. I call upon each of us to help monitor the quality of care being provided to our needy and elderly. We ask you to forward any information on quality problems to the committee so that we can prepare for upcoming hearings on this very important issue.

We are not only seeing declines in quality, but we are losing some of the gains we've made in making health care more accessible for the poor and the elderly, and many of us in Congress believe that Medicare and Medicaid have never adequately ensured access to health care.

The time has come not to reduce access but rather to move forward on resolving remaining access problems.

I want you to know that there is a great need for major Medicare and Medicaid reform. Though cost containment should be part of that solution, the cost savings should be used to maintain the viability of Medicare and Medicaid, and to improve access for the poor and the elderly.

Any such reform bill certainly should place full access to health care back on the agenda as the top priority.

The bill should make sure that the quality of health care is not lost in our rush to contain costs.

As you can clearly see, we have a full agenda facing the Aging Committee. The Congress and the American public are concerned about our elderly. I am looking forward to hearing from our expert witnesses today, here in El Paso, on how they feel we can better improve the Medicare and Medicaid Program in the short term, and what major changes are needed in the long term.

Before we hear from our witnesses, I would like to express my appreciation to Congressman Ron Coleman. As many of you all know, there are two types of Congressmen in Washington: show horses and work horses. Ronald Coleman falls in the second category because he is one of the hardest working Congressman that we have, not only in his position on the Appropriations Committee, but his sensitivity to the problems facing our elderly and poor with respect to health care is beyond reproach. He has led the fight throughout Congress on this most important issue, and with respect to Social Security has been one of those people who has had the courage to stand up on behalf of our elderly.

So, it is particularly pleasurable to be here today with Ron and his staff who have done an excellent job in preparing us for these

hearings, and I also want to thank those members of the Select Committee on Aging staff who are here and who have helped us do this.

At this time, I would like to call upon my dear friend and colleague from Arkansas, Tommy Robinson, who as a member of the Select Committee on Aging, is serving with me today on this panel, for any opening comments he may have.

Mr. ROBINSON. Thank you, Mike.

STATEMENT OF REPRESENTATIVE TOMMY F. ROBINSON

In order to save time and to allow our fine panel of witnesses to have more time to advise us of their particular concerns, I would like to ask unanimous consent that my opening statement be accepted in the record.

Mr. SYNAR. Without objection, it will be.

[The prepared statement of Mr. Robinson follows:]

PREPARED STATEMENT OF REPRESENTATIVE TOMMY ROBINSON

I want to thank you, Mr. Coleman, for inviting me and my colleague, Mr. Synar to the fair state. Since I came to Congress this January, I have had the opportunity to travel to several different areas of the country with colleagues to hear first hand the effects of government rules and regulations. This direct input from the people is invaluable and I am pleased to be here.

The subject we address here today—how well Medicare and Medicaid programs serve their unique purposes—is of critical importance. We have all heard about the "graying of America" and I am especially alarmed at the projections for the growing population of frail elderly.

And at the same time our elderly population is increasing, the federal government's determination to provide for these health care needs has been called into question. $200 billion deficits cast a shadow over the ability to meet our commitment to health care for the elderly and poor of this nation.

In this 20th anniversary year of the enactment of Medicare, the elderly find themselves paying out of pocket 15 percent of their entire income for health care. This is the same proportion of income they dedicated to health care *before* Medicare came into being in 1965.

The poor and near poor fare no better. Fewer than half of the poor are covered under the Medicaid program and a conservative estimate puts at between 20 and 30 million the number of Americans without any type of health insurance.

Both the Medicare and Medicaid budgets came under heavy fire in the House and Senate. The breakdown of negotiations in the House-Senate budget conference is a clear indication of just how serious the budget cutting mood is on Capitol Hill.

But in this rush to slash the deficit—and as a boll weevil from Arkansas I am among the first to say that we need to achieve significant reductions in the deficit in fiscal year 1986—we cannot forget to factor compassion into the equation.

Too often budget cutters and administrators focus on dollar signs and deficits and not on people. There is some reason to suspect that some of Congress' cost saving measures—well-intentioned as they were—have led to a deterioration in health care.

Peer Review Organizations (PROs) and the Prospective Payment System (PPS) have played to mixed reviews. And the jury is stillout on Diagnostic Related Groups (DRGs). I am disturbed by reports of denials of patient admissions and premature release of patients. I am concerned about the effect of a possible continuation of the freeze on physician reimbursement fees.

As I reviewed the list of witnesses testifying today, I was pleased at the scope of perspectives we will have on this issue. Let's hear what they have to say and get down to the business of getting the most "bank for the buck" for the scarce federal health care dollars.

Mr. SYNAR. At this time, I will call upon our host and friend, Ron "Shooting Star" Coleman.

STATEMENT OF REPRESENTATIVE RONALD D. COLEMAN

Mr. COLEMAN. Thank you, Mike.

I want to, first of all, welcome these two fine, young Congressmen from the U.S. Congress.

Chairman Mike Synar, as he pointed out, is from Muskogee, OK. He serves also on the Energy and Commerce Committee, which is of great interest to me, of us in Texas, and certainly to his own State of Oklahoma.

I had the pleasure of serving on the same committee with him in my first term, on the Government Operations Committee, where he chairs the Subcommittee on Energy and the Environment.

We have a great opportunity in having him here with us in El Paso to see one of the really bright young Congressmen that has arrived in Washington, DC.

He was elected in 1978 to the Congress, at the age of 27. I think you can tell from his opening statement, he shares those same concerns and feelings we share here in our own community where we are known somewhat for the problems and difficulties we have had in getting health care services to people. Because of our underserved areas in some regions of our county and in this 16th Congressional District, I think it is very important for us to address these issues to this particular select committee.

I am also very pleased to introduce to you Congressman Tommy Robinson. He is a freshman Member of the Congress. He came to us from Jacksonville, AR. He was sheriff of Pulaski in Arkansas from 1980 to 1984; director of public safety of Arkansas; chief of police of Jacksonville; and I have to say to you that certainly there are those Members also in categories, as we tend to place, some of whom are called shy, retiring Members. Certainly, he does not fit into that category.

Tommy Robinson has been very outspoken on the issues. He is representative, I think, of some of the new ideas and thinking that needs to go in the U.S. Congress. He brings with him some real strong feelings from the State of Arkansas about how Congress should act and react to certain situations on a global scale as well as in terms of our own domestic policy.

I have requested this hearing of the Select Committee on Aging in El Paso because I feel that it is imperative that we address the financial burden of health care that threatens our Nation's indigent and elderly population.

This issue is of particular importance in Texas, because this State has the fifth largest population in the United States of people over the age of 60.

The elderly are one of the groups that suffer most from the high cost of health care and gaps in health insurance coverage because they need so much more health care than other members of our population.

In looking at the growth trends in the elderly population since 1970, it has been projected that through 1987 this group will have grown 38 percent nationwide. It is important to point out that this same growth in the State of Texas will be 55 percent.

The Medicare Program now serves 30 million elderly and disabled citizens. Medicaid serves 3 million of our medically needy elderly people.

And still 5 million Americans do not even seek the health care that they truly need because they know they cannot pay.

The end of this month marks the 20th anniversary of the initiation of Medicare and Medicaid, and so I think it is important that this committee be here to listen to you.

I am going to ask the chairman to perhaps at the end of the meeting change the format. I wanted to go through the entire testimony of those who desire to testify, permit the committee, of course, to ask questions, but at the end, I would also ask those of you who would like to testify to please come to the back microphone at the end, and try to give what we, in Congress, call a 1-minute statement, and that means trying—at least, let us have the benefit of your thoughts.

And I am going to ask that the chairman allow that to occur, and I would at this time say to both of you, I am just as proud as I can be that you have taken out time from your busy schedules and your other committee responsibilities to come out here to West Texas.

We appreciate you.

Mr. SYNAR. Thank you very much, Ron, and we will, at the end of the meeting, want to hear from everyone on the 1-minute basis so that we can have full testimony.

Let me apologize beforehand. Because of the plane schedules, I will be leaving here in about 45 minutes to get back to Washington, but Mr. Robinson will be chairing the meeting, and Tommy and Ron will stay as long as people have those 1 minutes. So, we do look forward to that.

Our first panel will be two State representatives from the State of Texas; and if they will come forward right now, we have the Honorable Nancy McDonald and the Honorable Jack Vowell.

We would like to welcome both of you here today. I have heard some very nice comments from Ron at lunch about both of you and the outstanding work you are doing up in Austin, and we look forward to your testimony.

Your entire testimony will be made a part of the record. If you would like to summarize your testimony, that would be perfectly fine, too.

STATEMENT OF HON. NANCY McDONALD, STATE REPRESENTATIVE, TEXAS HOUSE OF REPRESENTATIVES

Ms. MCDONALD. Mr. Chairman and members of the committee, I would like to summarize, very briefly, my testimony, and focus on the indigent health care legislation which we have just enacted in this State, and how it will or will not affect the elderly.

First of all, there were four bills, major bills that were included in this package of legislation. The first one was entitled "The Texas Indigent Health Care Act," and that clarified the responsibility of the county and the hospital district and the public hospitals.

It also established an income-based definition for the indigency for the purposes of the program, and it appropriated the money for the fund.

Basically, this law states that the county must provide 10 percent of its general revenue for the care of its indigent and the State will fund the cost on an 80–20 split after it has reached that ceiling.

These services must include inpatient and outpatient care services, rural health clinics, laboratory and x ray, family planning, physicians' services, payment for not more than three prescriptions, and skilled nursing facilities.

We appropriated $63 million in the State for this program, and the breakdown of the appropriation is in the testimony.

The second bill was called "the Texas Primary Health Care Services Act," and it is designed to establish an integrated framework for the equitable provision of basic services throughout the State for those with no other health insurance coverage.

Approximately, at this time, there are 90 counties in Texas with no primary health care services, and when we say primary health care we mean diagnosis and treatment services, emergency services, health education, those other low-cost ambulatory services that are needed for health care.

Another one of the bills was "the hospital transfer bill," which was very important to the package, because it is set up that each hospital licensed in Texas must have a specific patient transfer policy with civil penalties if they do not.

And that, unfortunately, was a tragic occurrence for many of our elderly because we found that public hospitals were having patients dumped upon them who could no longer pay for care in a private facility or other facility.

So, this bill was very important to the care of the indigent.

"Maternal and Infant Health Improvement Act" was the last bill that was covered in this package. We recognize the role in investment and cost savings in taking care of the medically indigent pregnant women and the children born of this population.

We had a high number here in Texas, and the cost to the State was astronomical, and we found that by offering this preventative service of prenatal and perinatal programs, and for the high-risk infants in the neonatal care that we could prove that we would have cost savings across the State and better citizens because of it.

This passage of the health care package is an important achievement for Texas, and I believe that it shows our commitment to providing adequate health care for those at the bottom of the economic ladder.

Despite these gains, the State will continue to have problems in this area because, first of all, they only appropriated $63 million for this fund for the next 2 years.

We did not ensure any ongoing funding for the programs, and many believe this is not adequate for the ambitious goals that this legislation set out.

Also, this does care for those who are 25 percent of poverty levels so we would consider it covers the cost of the poor.

I think Congressman Coleman pointed it out very well the statistics that I have also included in my testimony that Texas has a growing aging population.

We might point out that particularly in this west central Texas area 21.2 percent of the 1980 population is aged 60 or over.

Also, in this Texas/Mexico border area, we have 30 percent of the population that falls below the poverty level, so the incidence and the indications that this will be a rapid growth in not only the number of elderly but of the elderly poor.

So, we might say that clearly the myth that "Texans are young and well-to-do" is just that—it's myth. We still have pockets of poverty and the elderly poor do exist.

This legislation that we have just passed does have some benefits for the elderly, and I would think that primarily the primary health care services would be the best for them as far as it would offer these services to them, closer to where they live, and emphasizing prevention and early diagnosis of their problems, to prevent what we have called "long-term neglect" so that they end up going to the hospital or emergency rooms for much more costly care, and certainly a higher cost in suffering.

We, as I have said, still only provide services for the "poorest of the poor," and I think we need to expand eligibility requirements. There are still gaps in insurance coverage, as Representative Coleman pointed out.

We may find that these affect those 60 or 65 who find themselves suddenly displaced before they retire. Also, at the State level, we have found it much easier to find money and interest in programs for mothers and children. This may be due to historical or cultural bias, and you can see in the appropriations that we made that they did receive the most money.

However, I believe we need to concentrate efforts on the elderly as well. We need continued commitment and guidance from the Federal level. The necessity for this exists now as much as it ever has.

We are beginning to address the problems of indigent care. We are trying to spread the burden of responsibility for this care. We are having some difficulty doing this much, but I think Texas has taken a great step forward.

We need guidance and funding from Federal levels. Without it, we might be forced to step backward, not forward.

Thank you.

[The prepared statement of Ms. McDonald follows:]

PREPARED STATEMENT OF NANCY MCDONALD, STATE REPRESENTATIVE, TEXAS HOUSE OF REPRESENTATIVES

Mr. Chairman and members of the committee, I want to welcome you to El Paso and thank you for the opportunity to appear before you today. I am particularly pleased that you are here today to discuss health care for the indigent since the Texas State Legislature passed some important legislation on this topic only a little over a month ago. I am also pleased that you chose El Paso as the location for these hearings—this area has some characteristics that are of special significance for a discussion of indigent health care.

You will hear (have heard) from others on the medicaid and medicare programs in the state and on the projected impact of the various federal proposals regarding these programs. I would like to focus on the indigent health care legislation that

this state just enacted, how it will and will not affect the elderly, and the problems and issues that the state will face with regard to the indigent elderly.

THE TEXAS INDIGENT HEALTH CARE LEGISLATION

In 1983, the Texas State Legislature authorized the establishment of a two-year study to be undertaken by a Task Force on Indigent Health Care. In December, 1984, the 71-member Task Force issued its final report, including 50 recommendations for addressing indigent care in the state. Legislative proposals resulting from these recommendations were introduced and, after much debate and enacted. In general, the legislation is designed to:

Extend health insurance coverage for the indigent population; improve uniformity by defining eligibility for charity care; achieve greater equity by distributing the burden of providing and financing indigent health care; maximize the utilization of existing facilities to improve access to health care; increase the availability of maternity and primary services to reduce the unnecessary utilization of high-cost care; and preserve the ability of public facilities to provide high-quality care to indigents.

The package of legislation enacted includes four bills. They are:

1. The Indigent Health Care and Treatment Act

This legislation clarifies the responsibilities of public hospitals, hospital districts and counties, establishes an income-based definition of indigency for purposes of the program, and appropriates money to fund the package of indigent care bills. Under the provisions of the bill, counties without public health care facilities are required to commit up to ten percent of general revenue to fund indigent health care. If such a county spends this ten percent requirement, it can apply to the state for money. The state may then pay 80 percent of additional health costs above the county's ten percent.

Counties without public facilities can provide services directly or contract with private or public facilities. They must provide their indigent population with the following services: in- and out-patient hospital care, rural health clinics, laboratory and x-ray, family planning, physician services, payment for not more than three prescriptions per month, and skilled nursing facilities

Counties with public facilities are required to maintain current eligibility standards and level of service provision. Eligibility for services in counties without public facilities is the same as AFDC-Medicaid in Texas—25 percent of federal poverty guidelines. Thus, the new legislation includes those categorically ineligible for current state and federal programs, an estimated 70,000 Texans.

The bill appropriates $63 million to a newly-established Indigent Health Care Assistance Fund for FY86 and 87, including $3 million for state matching to counties for providing care. In addition, approximately $20 million will be spent by counties for indigent health care. The state's appropriation breakdown is as follows:

	1986	1987	Total
County responsibility	0.50	2.50	3.00
Medically needy	7.50	7.50	15.00
Perinatal care	6.75	15.47	22.22
Primary care	2.50	5.50	8.00
Women, infants and children	2.00	5.00	7.00
Integrated eligibility	.50	.75	1.25
Hospital transfer	.05	.03	.08
Hospital reporting	.20	.25	.45
Disproportionate share	2.00	4.00	6.00
Total	22.00	41.00	63.00

2. Texas Primary Health Care Services Act

This legislation is designed to establish an integrated framework for the equitable provision of basic services throughout the state for those with no other health insurance coverage. Under the provisions of the bill, the Texas Department of Health will establish a primary care delivery system, set priorities for services and coverage, and draw up and implement a long-term plan. The department is required to emphasize the use of existing public and private health, transportation and educational resources. Primary health care services required by the bill includes: diagno-

sis and treatment; emergency services; family planning services; preventive health services, including immunizations; health education; laboratory, x-ray, nuclear medicine or other appropriate diagnostic services; and other low-cost ambulatory service.

3. Hospital Transfer Bill

This legislation requires the Texas Department of Health to adopt rules governing patient transfers. The governing body of each Texas hospital must adopt a specific patient transfer policy as a condition of licensure. Civil penalties of up to $1,000 per day may be assessed against a hospital for failure to comply with its policy. Designed to combat the problem of patient "dumping," transfer must include:

Notification to the receiving hosptial and confirmation from that hospital that the patient meets the hospital's criteria to ensure appropriate medical and other services; use of life support mechanisms to stabilize and sustain the patient during transfer; provision of appropriate health care personnel to aid the patient; and timely transfer of medical records.

4. Maternal and Infant Health Improvement Act

Recognizing its role as an investment and cost-savings for the future, the Indigent Health Care Task Force identified prenatal and perinatal care as its top priority. This recently-enacted legislation authorizes the Texas Department of Health to establish a prenatal and maternity services program for low-income women who are ineligible for Medicaid or other health care benefits. The following services will be available for these women:

Maternal and infant health improvement services, including prenatal and perinatal care, obstetrical consultations, neonatal intensive care, follow-up care for high risk infants, and emergency transportation; ancillary services; a special program of preventive, health and education services for adolescents; health education and health promotion services; and a special program of pregnancy prevention for women receiving benefits for two or more pregnancies, including family planning services.

Passage of the indigent health care package is an important achievement for this state. I believe that it shows our commitment to providing adequate health care for those at the bottom of the economic ladder. Further, it indicates that we are moving towards ensuring that care in an equitable and responsible manner, by broadening the service and financial burden, and by emphasizing basic care.

Despite these gains, this state will continue to have problems in this area. First, we managed to find $63 million to fund this program for the next two years. However, we have not ensured any ongoing funding for the programs, and many do not believe this money is adequate to implement the ambitious goals set out in the legislation. Second, we still have only dealt with the very poorest of the poor. The new laws do nothing to provide care for those at 26 percent of poverty and above although approximately 32 percent of those between 25 and 75 percent of poverty and 22 percent of those between 75 and 100 percent of poverty in Texas also have no health insurance coverage.

EFFECTS OF THE INDIGENT HEALTH CARE LAWS ON THE ELDERLY IN TEXAS

In addition, the new legislation in many ways does little for the indigent elderly in Texas. Since eligibility requirements under the new laws is patterned after the medicaid guidelines, it is unlikely that older Texans will receive extended coverage. Further, over two-thirds of the money appropriated by the state will go to pregnant women, new mothers, infants and children.

The fact that this major state initiative will have little effect on the indigent elderly is particularly disheartening considering the rapid growth in the number of senior Texans. According to the 1980 Census and Texas Department of Health projections, there were more than 2.1 million Texans 60 or older in 1984. By the year 2000, projections indicate that there will be more than 3 million Texans in this age group—an increase of 68 percent in 20 years. The most striking population increase will be seen in the 75 and older age group. In the next years, this group may increase by more than 130 percent—from 524,000 in 1980 to over 619,000 in 1984 to more than 1.2 million in the year 2000. (See Table 1 and Figure 1.) Although many of these elderly persons will not be classified as indigent, these figures do give some indication of the situation we will be facing. More specific data estimates that 4.2 percent of the Texas population, 709,405 persons, will be over age 60 and living below the poverty level by 1986. (See Figure 2.)

More specifically, some of the available demographic data reveal that certain areas of the state may face more critical problems. For example, the West Central Texas Area, which included El Paso, reports that 21.2 percent of its 1980 population was age 60 or over, compared with a statewide average of 13.4 percent. Similarly, in the entire Texas-Mexico border area, 30 percent of the population falls below the poverty level, despite the fact that Texas ranks 17th among the states in per capita income. There are a number of indications that this border area in particular will experience a rapid growth in the number of elderly persons, many of whom will be low-income. Clearly, the myth that Texans are young and well-to-do is just that—a myth. Pockets of poverty and of elderly poor do exist in this state; some are just beginning to manifest themselves. While the indigent health care legislation broadens the responsibility for health care for the nonelderly population, it does not do so for Texas seniors.

Enactment of the legislation does indicate that Texas is moving towards taking a more active role in aiding the indigent among its population. This is a new emphasis in our state, and one that should be encouraged. As we become more involved in this area, I believe we will begin to recognize and address the problems of the elderly as well as those we are now starting to focus on.

I do think that elder Texans will reap some benefits from the package. For example, the new emphasis on primary care is aimed at establishing a system of high-quality basic care across the state. Seniors, as well as recently-eligible indigents, stand to gain from this. As basic care facilities become more common-place, we may begin seeing many of these services extended to the elderly. Further, provision of these services to newly-eligible indigents will hopefully pay off in the long-run—as these adults reach older ages, many may not require that greater care that long-term neglect of their health would mandate.

In particular, the so-called county responsibility and hospital transfer provisions of the new law will protect a number of Texas' indigent elderly. In the past, we have seen a number of counties and private facilities "dumping" patients on public hospitals. For the elderly, this problem has been particuarly tragic. Under the new provisions, counties will be required to provide or contract for care for their residents. Hospitals will be required to ensure that any patient transfers are undertaken in a medically appropriate manner.

THE INDIGENT ELDERLY IN TEXAS

I would like to draw some conclusions about health care provision for the elderly, and particularly the indigent elderly, and to make some recommendations for action at both the state and federal levels.

1. We are still only providing services for the poorest of the poor.—In Texas, medicaid is only available to those living at 25 percent of the poverty level. These are the very poorest of the poor. We are doing little for those from 26 to 100 percent of poverty or above. In light of this, any discussion of a copayment for Medicaid, as the administration has proposed, seems absurd. We do not need to further burden these people; we need to expand the eligibility requirements and/or establish a "medically needy" program for the elderly.

2. There are still gaps in insurance coverage.—For example, unemployed persons have no access to Medicaid. This may severely effect those over 60 or 65 who find themselves displaced before they retire. In addition, we are doing little for those Medicare recipients who find it difficult to meet their deductible and copayment responsibilities. As noted, these may be people living at 26 percent or so of poverty; clearly, any attempt to increase these copayments would unduly burden these people. Most likely, the result of these increases would be much like what we see now among people who cannot afford these costs: They postpone necessary treatment until their condition is critical and/or they end up using more costly, and more serious, emergency care services.

3. There are still necessary services that are not covered by Medicare or Medicaid.—For example, medicaid provides reimbursement only for institutionalized care in this state, even though this care may be three to five times more costly than noninstitutionalized services. Medicare does not cover dental or eye care, even though these services may be vital for those over 65.

4. We have still not really recognized or addressed the health care needs of the elderly.—At the state level, we have found it much easier to find money and interest in programs for mothers and children. This may be due to historical or cultural biases, or it may be because of the direction we have received from the federal level. For whatever reason, however, this emphasis can be seen in our recent legislation: We expanded the "medically needy" program to include pregnant women and ap-

propriated $15 million for these people, we appropriated the bulk of the indigent health care assistance fund money—$22 million—to the perinatal program, and we set aside another $7 million for the WIC program. I think these programs are a wise investment. But, I also believe that we need to start concentrating efforts on the elderly as well.

5. We need continued commitment and guidance from the federal level.—Now is simply not the time for the federal government to relinquish the responsibility it has undertaken with regard to health care. These national programs were established in order to provide basic care in a uniform and equitable manner. The necessity for this exists now as much as it ever has. In Texas, as I have noted, we are trying to do some new things: We are beginning to address the problem of indigent care, we are trying to spread the burden of the responsibility for this care. We are having some difficulty doing this much; but we are now beginning to provide some services that we have not recognized as important enough to fund in the past. We need guidance and funding from the federal level most now—without it we will be forced to step backwards, not forwards as we are slowly beginning to do.

TABLES

Projected Increases in the Texas Population

Year	Total Population	Age 60-64	Age 65-69	Age 70-74	Age 75 +	Total Age 60 +
1980	14,229,000	532,000	476,000	371,000	524,000	1,903,000
1984	15,779,000	579,000	523,000	399,000	619,000	2,120,000
1990	19,198,000	680,000	618,000	455,000	815,000	2,568,000
2000	27,855,000	847,000	736,000	613,000	1,286,000	3,482,000

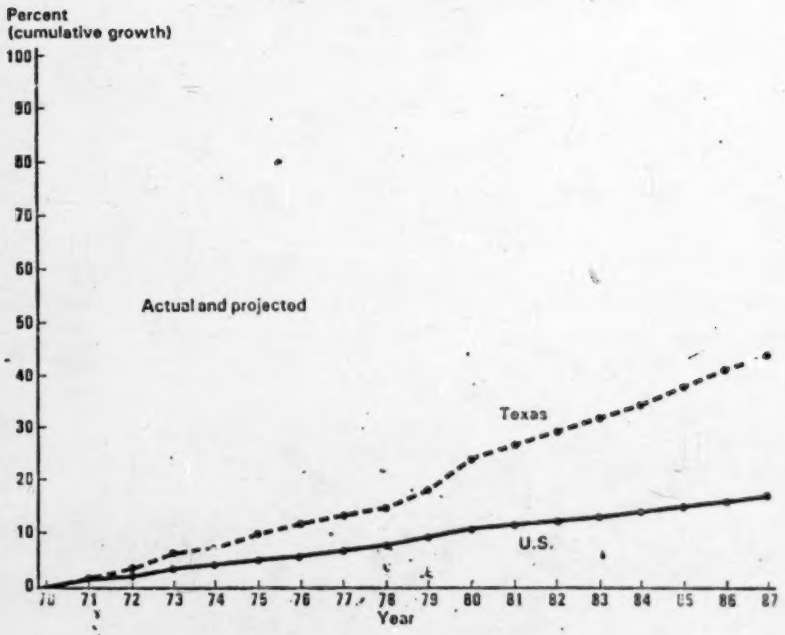
(Figures rounded to nearest thousand)

(Source: Texas Department of Health, Population Data System – 1009206)

* Information courtesy: *Texas Long-Term Care Plan for the Elderly 1984–1986*

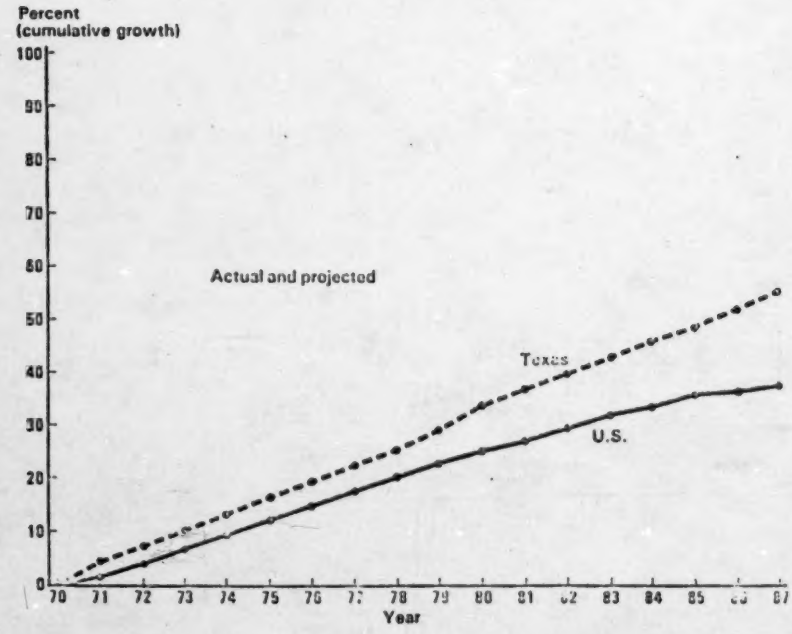
Growth in Total Population

Texas and United States



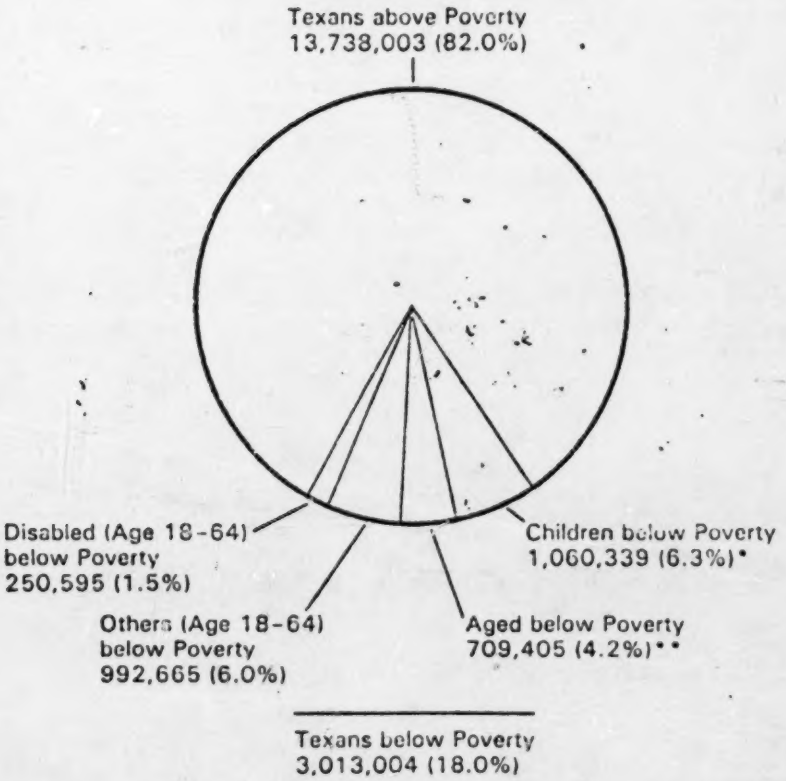
Growth in Elderly Population

Texas and United States



Texans by Income

Estimated 1986



* Includes 25,629 disabled children below poverty level.
** Includes 395,659 disabled aged below poverty level.

Note: Texas Population – 16,751,007. The poverty level for a family of three is $9,340.

Source: DHR 1981 Biennial Survey and Texas Department of Health Population Projections. Prepared by Budget and Planning Division, January 10, 1985.

Mr. SYNAR. Mr. Vowell.

STATEMENT OF HON. JACK VOWELL, STATE REPRESENTATIVE, TEXAS HOUSE OF REPRESENTATIVES

Mr. VOWELL. Thank you, Mr. Chairman.

My testimony is rather brief and, to some extent, general, so I hope you will ask any questions that you may have.

An 80-year-old friend of mine once said to me. "The trouble with our society today is that we buy what we want, and we beg what we need." And from whom do we beg? Why, of course, we beg from the Government. I need not tell you gentlemen of the constant, unrelenting demand for governmental services and funding which confronts all of us. However, I would strongly suggest that the time has come for you to hold the line. I believe it is absolutely essential in order to maintain the fiscal integrity of our national Government and the future stability of our Nation's economic social and political systems.

But, having said that, I am also convinced that properly done, our State government and our National Government can provide expanded services at the same or lower costs, services which will allow us to be more responsive to the needs of our citizens and to do a better job with what we undertake.

As you may or may not know, the State of Texas is required by our Constitution to have a balanced budget unless the legislature suspends this rule by a four-fifths vote of both Houses. Thus, any appropriation made by Texas is null and void unless the Comptroller certifies that the funds will be available from projected revenues. I mention this because it has a limiting effect upon the dollar amount of Federal funds which our State will match under any given circumstances. This requirement for a balanced budget acts in effect as a break upon the amount of Federal funds sought, and you will hear today, I am sure, a number of statements by people who will tell you that we do not ask for or receive enough Federal funds. And one of the reasons for this is our constitutional limitation. What this also does is to force us to prioritize very carefully, to spend our money as efficiently as possible, and constantly to seek new ways for meeting the needs of our citizens.

With respect to the Medicaid and the Medicare programs for the elderly, we have been able through health care cost containment programs to reduce the annual increase in medical costs from 14 percent in 1981 to 4 percent in 1985. Last year's increase was about one-half of the national average. By emphasizing community-based care, primary health care and home health services, we were able last year to save $120 million. All in all, the total Medicaid cost containment programs, both for the elderly and others, resulted in a saving of about $191 million in fiscal year 1985. And it was these savings which were used to expand the scope of our overall Medicaid programs to include the medically needy, and several other needed health care programs for the indigent. Yet, we could have done more, I feel, if Federal regulations had allowed us more flexibility.

Excessive monitoring and expenditure caps which institutionalize past spending patterns, inequities in the distribution of funds, and

penalties for bureaucratic errors impede rather than enhance program viability. I was interested, Mr. Chairman, to hear your comments about program access. The delivery system is the crucial part of any health care delivery system, or any social service or governmental program. And if our delivery system is clogged with unnecessary requirements relating to bureaucrats, our bureaucratic demands, then, of course, the people we are trying to serve are simply left out in the cold.

When you are hungry, 6 weeks is too long a time to wait for food stamp eligibility; and that is what the normal length of time is we have in Texas for determining whether a person is eligible. Hiring more people, dealing with these problems is not necessarily going to solve that problem. And, of course, the frustrations that this type of thing creates are tremendous. Filling out forms is no way to assuage fear or pain or suffering, when you are sick.

So, my plea to you today is to help us cut through the red tape so that we can provide the appropriate kinds of services that our aging population needs. If you must freeze funding—and I am not advocating that—please do it in a way that puts your dollar where the people are. The aging population in this State are growing at a rate 20 percent faster than the rate in the rest of this country; and, increasingly, as you pointed out in your opening statements, they are falling below the poverty level, and they need help.

Today, in Texas, we have about a million children who are below poverty, and we have about 710,000 elderly who are below poverty. And we are not serving but about 25 percent of each of these groups. Increasingly, we need to have flexibility so that we can be innovative, responsive, and efficient. If you give us this flexibility, I believe the people of Texas will respond.

Representative McDonald has talked to you about the Indigent Health Care Program, and I think one of the most significant events of our recently concluded session in the Texas Legislature was the fact that our human services budget was increased by more than $100 million. And this was done at a time when all of the other departments, save two, were being cut back because of budgetary restraints.

The other significant thing was that, at least, the Department of Human Services budget was passed without a single dissenting vote, and I think Representative Coleman can tell you that is sort of a landmark situation.

Mr. COLEMAN. That's impossible.

Mr. VOWELL. It was not opposed in the Appropriations Committee, and it was not opposed in any way on the floor of the House.

Certainly, this indicates a willingness, and I think a recognition by this State to provide the resources and the services which are needed by our citizens, both young and old.

I can only hope that you will help us in maintaining this long-needed initiative.

And before I close, although that is the end of my formal statement, I would like to point out to you that we need to be given the chance to innovate.

I have before me today a proposal for a Respite Care Program for the Aging in this county, by the El Paso County Council on Aging.

The problem here is that it does not fit into any of the recognized programs. It cannot be funded. We have 35,000 people in El Paso County who are over the age of 65, and about 10,000 of those are below poverty. They need help. We can give it to them in a nursing home, which is expensive; we can give it to them in a hospital, which is expensive. Or we can provide some kind of contact or network of support in their homes.

In the last legislature one of the things that I worked on most avidly was what is called "The Hunger Omnibus Bill."

And we discovered something which, I think, is tragic in this country; and that is that there is an increasing and growing population of people who are hungry in this State, and I am sure in this country; and they are hungry because food is becoming the variable in their family's expenses.

They do not qualify for a poverty program. They have too many assets. Many of them are retired. They have homes, but by the time you pay the utility bill and the tax bill and the telephone bill and the other things you need to pay, you do not have enough money to buy food.

And I am sure you will hear some more testimony about this today. I can tell you about a constituent of mine—in fact, a neighbor of mine who came up to me in casual conversation, simply related that she and her husband lived on a food budget of $28 a week. That is a very small budget in today's world. She is not someone that you would think was in great need.

But what is happening is that we have a social dislocation of massive proportions. The elderly which are a growing segment of our society are not ignored, but we have not found a solution to their situation.

I think that this is the most critical situation that our country faces in the future, and I hate to think of the consequences of what will happen in 20 years when half of our people are my age or older.

It is going to be a very difficult situation for the young and for the mature working people if we do not find some way to give these people a viable social role, both economically and politically in this country.

Thank you.

Mr. SYNAR. Thank you very much, Jack, and I want to thank both you and Nancy for your excellent testimony.

Let me ask one question, if I could, and I would like to combine both of your testimonies.

Jack, you pointed out that here in the State of Texas, there is over 1 million children who are below the poverty level.

Mr. VOWELL. That is right.

Mr. SYNAR. And there are over 710,000 elderly below the poverty level. Right now you all are only able to deal with 25 percent of those.

And, Nancy, you point out in your testimony that the State of Texas has 90 counties that do not have primary health care.

If my figuring is correct, that is 35 percent of the State, by area, not necessarily by population.

My question is: Are those two figures parallel with these people who are in the 1 million children category and the 710,000 elderly? Are these people most likely to be in those 90 counties?

Ms. McDONALD. Those 90 counties are usually those that are sparsely populated, so the area would make a significant difference.

However, also those counties are on the Texas/Mexico border area, which would also take into—that into account would mean that there are more that are below poverty level in that area.

So, you could almost say it was half and half.

Mr. SYNAR. The reason I asked you that question is that whatever we do to have a combined effort between the State of Texas, or any State, and the Federal Government would go for naught if we do not have the access system, as Jack pointed out, to deliver it once we got the services there.

If 90 counties do not even have primary health care and delivery systems, then it will not matter how much money we put in, we will be missing the target; which is literally throwing money out the window if the services cannot be delivered.

Ms. McDONALD. Well, this is what we have hoped to alleviate with our primary health services act, and it will not be done overnight; it will take time, and it will take funding. It will be done through the Health Department—the Texas Health Department; and according to the need for the services that are prioritized as the most critical.

And included in those services would be transportation so that they could provide services that would be closest to those residents, which is a very important factor for the elderly.

We stress that it will include at least 70,000 new individuals that have not been taken care of before; and those are indigent individuals, too, some of them.

Mr. ROBINSON. Jack, you talked about the "bureaucratic maze," and I listened to you very intently because I know that is one of the problems that we experience in Washington, DC.

But I would like to ask you a question. As we all know, Medicaid is administered by the State. These are the Medicare basically, as administered by the Federal Government.

The Senate, in their budget proposal—they saved $16.3 billion over 3 years with some increases in out-of-pocket costs to beneficiaries.

The House saves $13.1 without added costs to beneficiaries.

The Senate calls for freezes or changes in Medicare payments to health care providers, and the House calls simply for a freeze.

I bring that up to put into some sort of perspective what I think the problem is, and I would like to listen to both of your viewpoints.

In my opinion, for the most part, we have had more success with Medicaid than we have with Medicare because the States have, for the most part, administered the substantive part of that bill.

Do you think that we could save money if we shifted more of the bureaucratic burden onto the States for Medicare similar to what we did with Medicaid?

Mr. VOWELL. I certainly do. I think that there are many ways in which you can "skin a cat."

And what one of our problems has been is that each State is different. I tried to point that out in my testimony. And for us to fit into a pattern that is applicable to New York or to California or Iowa is not always possible.

But if we have the flexibility, I think we can have the ability to get the results you want. We can make sure that funds are disbursed properly, that there is no fraud and that there is no abuse.

But the more money that we have to spend on fitting into a pattern, the more difficult it is going to be for us to do the job. But, as a matter of fact, Texas has looked at the Medicare Program in relation to a cost containment modality, and they are looking at several different kinds of things for their Medicaid.

And, quite frankly, they prefer at the present a different tack, and in the next 3 or 4 months, we are going to examine this legislatively and departmentally to see if there is not a better way to do it than the DRG.

I agree completely with what the chairman said. The thing that concerns me most is that by containing costs, we keep people from having adequate care, and I do not think that we or anyone else—certainly not I as a layman am capable of determining what the medical or health care needs of a person might be.

Mr. ROBINSON. I do not mean to interrupt, but I bring it up because we are always trying to find ways to save money. It appears to me that each time that we come up with the new cost-saving mechanism, it is always to the detriment of the beneficiary; and I for one would like to look at how we could save money in reference to bureaucratic costs and maybe shift some of that burden.

I would like to interject something also. I had a constituent recently—talking about the DRG's—and I was about half asleep until you brought up the DRG's and I started getting a little bit mad about that—I had a constituent in one of my counties that went to the hospital with pneumonia, and the lady had a heart attack while she was in the hospital. They would pay for the pneumonia diagnosis, but they would not pay for cardiac arrest.

And that was one of Stockman's—and by the way, I know some of you know David Stockman was admitted to the hospital recently, Georgetown University—and we have an update on his condition. They tried to implant a human heart and his body rejected it.

That is basically—and I am glad you brought that up; but the bureaucratic procedures that come out of Washington and trickle down to the States and the counties and cities and to the people that really need the help, it is just unbelievable, the burden that we place on the providers and also the recipients.

And we are experiencing in Arkansas, now that many of our nursing home facilities will not accept Medicare patients, because of that bureaucracy that one has to deal with, and they find that the cost is counterproductive to staying in business.

Thank you.

Mr. SYNAR. Ron.

Mr. COLEMAN. Go ahead, Jack.

Mr. VOWELL. I would just like to say something which I think is important, and I cannot prove it, but you will hear testimony today from a lot of frustrated people, people that have been unhappy with the status quo.

And I think that one of the basic root causes for this frustration is the fact that they feel that they are being manipulated; and I think that we could save a heck of a lot of money if we just trusted each other, and if we judged things by results and not by process.

Mr. ROBINSON. Very good.

Mr. COLEMAN. I am not going to ask any questions in the interest of time. I have the benefit, Mr. Chairman, of knowing both of these fine legislators for a long period of time.

I would only urge both of you, in response to the overall issues that we are debating, to address a few questions about what action Government should take in terms of holding down health care costs for everyone, and more particularly, the elderly?

And what is the role and responsibilities of the Federal Government vis-a-vis the States.

Having served with you in the legislature, I can honestly say to you that I have a great deal of confidence in the statement that you made, Jack; about those State-administered programs. I would suggest that maybe it would be good for us to put those kinds of things into writing, and I will be more than happy to take the issues that you raise and your thoughts back to this committee in Washington, DC, and present it to them.

I am convinced that some of what you said is going to become very, very important in the future. We are sitting on a time bomb, in my view, with many children below the poverty level with our increasing rise in elderly population growing rapidly and so far ahead of others.

Nancy, if you had a comment, I would be happy to hear them. I would only hope that both of you would be willing to take the time and spend the time to give us that information. Nancy and I had an excellent visit in Austin before the session was over about another proposal that we had in Washington on the Medicare cap, and it is what we thought would be adverse effect on States, Mr. Chairman, who are doing a good job administering the program.

We would have wound up getting less money in Texas than other States because we were doing a better job for cost containment for the Federal programs we were administering.

I would hope that each of you would be willing to take the time, though, because I think through a State-Federal cooperation we can show others how to get things done.

And I appreciate very much, Mr. Chairman, your permission to let me ask some questions.

Ms. MCDONALD. If I may, I would just like to offer one more comment.

As part of the appropriations that we did make with this legislation that we have what we called the "integrated eligibility" section; and that would be to try to coordinate these efforts in the State, to make sure that we can very quickly and efficiently set up the eligibility and find those patients who are deserving of the care and to reach them as quickly as possible.

And, of course, to do that efficiently, we had to set aside money. So, we are striving to work in that area in Texas; and I might just add coming from a hospital where I have worked for 10 years, we did find many problems when the DRG was first instituted. I do not think that is going to be the answer to our cost containment.

And I would like to see Texas continue on with primary care and to emphasize prevention and to go further to help with the home health care and facilitate such things as this pilot project that Jack was speaking of today.

Mr. SYNAR. Thank you, both, Nancy and Jack. We do appreciate your testimony.

Mr. ROBINSON. Thank you.

Mr. SYNAR. Our next panel will be Mrs. Helen Bogas, Mr. John Danley, Mrs. Margarita Giron-Sanchez, along with Sister Murphy, and Mr. William Kennedy.

Those people will come forward, and take a seat at the table.

Mr. ROBINSON [presiding]. Mrs. Bogas, we will start with you.

STATEMENT OF HELEN F. BOGAS, SENIOR CITIZEN, EL PASO, TX

Mrs. BOGAS. Thank you, Mr. Chairman. Members of the committee.

There is evidence of increased concern among recipients of Medicare and Medicaid whose benefits may be reduced, suspended or terminated. Seemingly, the gap has broadened between an increasing need for benefits and the ability to maintain current benefit levels, placing serious pressures upon disabled citizens and the agencies involved.

And if this is a generalized statement, it is also a very personal statement of the kinds of serious pressures that affect you individually.

One, speaking as a one-family unit—a husband and wife—a cost increase of life-sustaining drugs, even generic drugs—and they are not always available—is rapidly making this very necessary therapy prohibitive because of cost increase.

I might interject here that our drug bill runs to around $250 a month.

Food, utilities, and other medical care costs; and, indeed, every aspect of general living expense continues to rise to a degree that makes it more and more difficult for disabled people to meet the basic needs of day-to-day living.

Two, those supportive agencies which have made a broad range of services available to a large spectrum of disabled people in our society are seriously handicapped in their efforts to do so.

One has only to examine and record the costs of medicines and therapies in just one extended hospital bill, one confinement, to realize that such charges, if they were covered by Medicare in an intensified type home-care setting, would be reduced enough to make the implementation and establishment of a multivaried type care program less expensive means for patients' care. This is not to say that every disabled person would benefit by such program all of the time as there will always be patients in need of technical expertise that only a hospital can provide.

Three, to be frustrated by costs beyond your ability to pay starts you to thinking and there must be a way to lower cost of patient care, and it does seem to me that an expanded type of home care programs, which has been expressed here, would be, if broadened some, one way to reduce costs and to give every recipient of that care better coverage at a price he or she can better afford.

Hopefully, there could be a better balance of services between hospital care that is so vital to the critically ill, and care that would be available and viable for those who could be treated at home.

Time seems to be running out for many people, and the need was yesterday.

Mr. ROBINSON. Thank you.

Mr. Coleman, go ahead with the rest of your members.

Mr. COLEMAN. Yes.

Mr. Danley.

STATEMENT OF JOHN A. DANLEY, MEMBER, TEXAS STATE LEGISLATIVE COMMITTEE, AMERICAN ASSOCIATION OF RETIRED PERSONS, EL PASO, TX

Mr. DANLEY. I really appreciate the opportunity to speak to you today, because as chairman of the Medicare survey that was published in the Times last June, I have had requests for help almost every week since then, and I have become involved in a liaison committee with the doctors here in El Paso, and also on a State level, and—pardon the expression—but I have really been "belly-to-belly" with almost every aspect of it.

I do not want to get into statistics because I have given Nancy all of the latest data from Washington that our people have. I would only add that El Paso, because of its low economy, probably would run somewhere between 50 and 75 percent of our elderly below $10,000 a year.

I think that becomes very important when you use the national figures that 80 percent of those over 65 depend on Social Security for 90 percent of their income, and 45 percent have incomes below $10,000 a year.

Our figures, I think, are pretty realistic, and are probably closer to 75 percent. So, I do not want to dwell on statistics. I want to just briefly mention what I think is wrong with Medicare.

One, it is completely unfair to people that pay for it, because while they pay the same premium on a nationwide basis, what they receive varies from State to State.

Texas, I have seen actual bills—$165 with a reasonable cost of $29; $85 bill, $17 reasonable cost. First, I blamed all of this on the carrier, but now as I have gotten closer to it, I find that Medicare is so complicated that there is a compounding of errors in submission of claims by doctors, and interpretation of claims by the carrier.

I would offer as a solution that they make a study of selecting one city as a median. They could take New York, Washington—wherever they wanted, and establish a criteria like the DRG for appendectomies, et cetera; and then they would apply a percentage factor for other areas to replace the economic variations they now have.

All they need is a simple percentage factor for each area. There is an organization called Marshall and Swift, I mentioned in my letter, based in Los Angeles that does this for real estate appraisers, and it is equally complicated or more so than Medicare. They keep it updated as required. LA is the median, and everywhere

else—I happened to be in Portland, OR, at the time—had a percentage factor to be applied to all items. It applied to everything pertaining to replacement costs for homes or industries. Medicare could do the same thing.

In Texas, we have, I am told, by people in HCFA, one of the lowest, one of the worst records in the country as to "reasonable costs."

I think the solution to this lies at the Federal level and not on a State-to-State basis. We could perhaps force HCFA to change a carrier, but I think the system should be changed. Its very complexity invites errors.

There is no reason why doctors should not know what their reasonable cost will be, whether it is 5 percent or 60 percent. As of now it is unpredictable. I think it may be unconstitutional for people to pay the same premium nationwide and receive different results on a State-by-State, or even an area-by-area, basis. Reasonable costs even vary doctor by doctor. It just is not equitable.

The other thing I wanted to get across—and to me this is very serious because I have not been able to help people with—relates to DRG, and I have talked to the doctors as recently as this week.

That is the fact that—and let's use a husband because there are more widows than there are widowers—he goes into a hospital on a DRG, and suppose it is a pretty expensive illness, and he is about to—I have talked to a doctor who is on the State peer organization. He tells me that the peer review in the hospitalization and the peer utilization and the peer review in the State cannot take care of these DRG's who are tossed out of the hospital because the hospital is losing money.

So, he goes into a skilled nursing facility, and he can only stay there so long; then, in order to get into a nursing home, he has to use up all of their savings and become an indigent in order to qualify for Medicaid.

And what does that do to the widow? She is left without a nickel; she is an indigent—in some States even the children are wiped out.

These are things that I do not think have been presented to you by AARP that I, as I say, have run into on a first-hand basis, and I really would appreciate your consideration of it.

I would be glad to supply case data and answer questions.

[The prepared statement of Mr. Danley follows:]

PREPARED STATEMENT OF JOHN A. (JACK) DANLEY, MEMBER, TEXAS STATE LEGISLATIVE COMMITTEE, AMERICAN ASSOCIATION OF RETIRED PERSONS, EL PASO, TX.

Thank you for including me as AARP's spokesman in you six member panel at the subject Hearing.

The timing is most fortuitious as I have been accumulating data since our Medicare Survey was piblished by The Times last June 24th.

Ron, I will refer to Social Security and Medicaid primarily as they relate to Medicare and of course my verbal testimony will be considerably shortened from this report.

As a member of a liasion committee with physicians in El Paso and also as a member of the State Liasion Committee of The Texas Medical Association and AARP I have been collecting data with hope of correcting some of Medicare's deficiencies especially in Texas.

This report will cover some aspects that to my knowledge have not been presented by AARP so I am also enclosing some reports presented by our Washington officials to your Committees.

Herewith are the salient points I would like to present:

THE ELDERLY are divided into three groups:

The "poor" old.
The "sick"old.
The "old"old.

Approximately 60% are Medicare beneficiaries.

80% of those over 65 depend on Social Security for 90% of their income.
15% of their income is spent on health costs.
43% have incomes below $10,000/year.
21% have only Medicare with no supplemental insurance.
The "poor" old are primarily on Medicaid.
If COLAs are reduced or frozen to a 3% annual inflation rate, 1½ million-mostly women-will be pushed below the poverty level and probably on Medicaid; by 1990 this figure will reach more than 2.3 million.

Some of these figures are drastically increased-even doubled-in Border Cities such as El Paso and in similarly economic depressed areas. There are 60,000plus Medicare recipients in the El Paso Area.

MEDICARE ANALYSIS.
Part A-handled by an intermediary, in Texas it is Blue Cross. Since this is between the hospitals and the intermediary as opposed to the beneficiary, I have received no direct complaints and will not comment other than that the new DRG program is meeting with varying reactions from the hospitals and is causing some problems from early discharges for terminal illnesses and the patient has to use up all savings to qualify for Medicaid. This is a real hardship for the spuse-usually a woman. I have had calls from three patients so far.

Part B-handled by the carrier-in Texas this is Blue Shield. The Intermediaries and carriers are selected by contract with HCFA and vary state by state.

There have been two major complaints from patients and doctors concerning Blue Shield.

Processing delays-one month is reasonable, but I have had complaints of six months to a year. I had three ladies phone me after the first of the year regarding claims that had been submitted August, 1984 and in spite of repeated follow-ups had not been processed. A man with local HCFA(Social Security Office) used his "hot line" and resolved two of the claims, the third received a check for someone in Corpus Christie,Tx. for more than the amount of her claim.

Reasonable Costs-this is an extremely serious situation, particularly in Texas-I HAVE BEEN TOLD BY MANY, INCLUDING HCFA OFFICIALS, THAT TEXAS HAS ONE OF THE POOREST RECORDS IN THE COUNTRY-THIS OF COURSE REFERS TO BLUE SHIELD.
The Medicare Part B Premium is the same nationwide yet "Reasonable Costs" vary state by state, arae by area and doctor by doctor-in Texas even by claims from the same doctor. I have seen claims below 20% of the Actual Charge, where an appeal resulted in only a token increase. It would require an investigation by a qualified individual with access to records in Dallas to pinpoint where the fault lies. but in the meantime it is causing mental anguish and financial hardships to too many elderly.

Guidelines are furnished by HCFA, but complicated coding that both carrier and physician's employees have difficulty following add to the problem.

Reasonable Costs vary by economic areas, which is understandable and are also listed in a Medicare Handbook as the lowest of:
The Actual Charges.
The Customary Charge for similar services generally made by the provider.
The Prevailing Charge in the locality for similar services.
NOT LISTED IN THE HANDBOOK IS A 4TH. CRITERIA; the carrier's usual amount of reimbursement for comparable services to its' own policy holders under comparable circumstances.

Ron, what I find difficult to understand about Medicare is that under Part A, the patient has recourse at law against the hospital and the intermediary, but under Part B they cannot sue the carrier. For major medical situations and a low reasonable cost many elderly are losing their life savings. Results from Appeals and Hearings with the carrier are reportedly very unsatisfactory-you can sue the government and every one else BUT THE CARRIER IS INVIOLATE??? I am no attorney, but it seems to violate the Constitution. Would appreciate your interpretation.

SOCIAL SECURITY AND MEDICARE-as previously noted 80 plus% of Medicare recipients receive 90% of their income from Social Security. Sharply escalating utility costs, suppplemental insurance costs and Part B Premiums are cutting heavily into their incomes-for many an impossible situation already. Denial of COLAs will result in further hardships and as noted a substantial increase in the indigent ranks.
It should be also noted that premiums for SMIs to pay up to Actual Charges have already increased beyond the means of most elderly even though they may have savings they need to protect. I am not exagerating when I say that those who are at all aware of their situation are panic stricken!
Also fewer and fewer insurance companies will even furnish policies that go beyond Medicare's Reasonable Costs.

MEDICAID AND MEDICARE-the relation here is that people who have worked and saved all their life toward a comfortable retirement and who have helped support indigents-many of whom may be 2nd. and 3rd. generation professionals, now are being forced to exhaust their savings and become indigents themselves to join the ranks of Medicaid-it seems ironic that only yhe wealthy and very poor can be assured of medical treatment without complications and delays-the middle class are in jeopardy.

SUGGESTION: though I could use more definative data, I believe that a Median Area could be established for 100% Reasonable Costs for all services; then a percentage factor could be applied for all other areas on an above or below 100% basis. A large firm in Los Angeles has been supplying this data to professional Real Estate Appraisers on a continuing basis and covering hundreds of categories. This would be not only simpler, but less expensive than the present structuring. This could then be expanded as desired to cover doctor's years, training and/or experience; if warranted, also their fee structure and class of patients. I do not feel qualified togo into detail on these aspects. BUT-
SOMETHING MUST BE DONE TO EQUALIZE WHAT BENEFICIARIES RECEIVE ON A NATIONWIDE BASIS. This should also increase doctor's acceptance of assignment, knowing what the Reasonable Costs would be for each service.Thank you, Ron, for any assistance or information you can furnish.

Warm regards,
Jack
John A.(Jack) Danley, Member TSLC
Chairman, El Paso Medicare Survey

cc. AARP Staff
AARP Concerned volunteers

ATTACHMENT A

AARP

January 10, 1985

CUTS IN SOCIAL SECURITY COST-OF-LIVING ADJUSTMENTS (COLAS):

IMPACT ANALYSIS

At the top of the list to reduce the deficit is social security, particularly the annual cost-of-living adjustment (COLA). One of the quickest and largest single cuts that can be made in federal budget expenditures is to cut COLAs. For example, reducing the COLA by 3 percentage points (the so-called "CPI minus 3" option) would save $4.2 billion in 1986 and $30.7 billion over the 1986-88 period. A one-year (1986) freeze would save $7.4 billion in 1986 and $27.2 billion for the 1986-88 period.

AARP has consistently opposed cuts in COLAs, particularly because of their impact on the poorest --usually the oldest-- among the elderly. These low-income groups have the highest dependency on social security. As illustrated by Chart 1, those persons with incomes below the 1981 poverty level ($4,399) depended on social security for over 90% of their income. Because of this high degree of dependence on social security, any cuts in the program or reductions in COLAs would have the harshest impact upon the most vulnerable members of the older population. It is for this reason that the 1985 DRI Study on the impact of COLA cuts (available from AARP upon request) indicates that COLA cuts would push an additional 500,416 older persons below poverty in 1986 if a "CPI minus three" proposal is enacted.

Is social security a "middle-class" entitlement program?

Much has been said about the so-called "middle-class" entitlements. But, who really benefits most from social security? Not the wealthy, they draw only a fraction of their income from social security. Chart 2 illustrates the total income distribution of aged social security beneficiaries. This chart clearly demonstrates the high concentration of social security beneficiaries at the lower end of the income scale; in fact, the highest concentration is in the $4,000 to $7,000 range. The fact is that those who benefit most from social security are the poorest and most vulnerable among the older population.

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700

Vita R. Ostrander *President* Cyril F. Brickfield *Executive Director*

ATTACHMENT G

AARP

SOCIAL SECURITY/MEDICARE AND DEFICIT REDUCTION

Fact Sheet

Older Americans have borne the burden of substantial amounts of budget reductions in the past 4 years.

Table I illustrates already legislated federal reductions in spending for the aged. Over the course of fiscal years 1982-1985, older persons have been asked to "cough up" almost $26 billion in the name of deficit reduction. The deepest of these cuts have come in the form of social security and Medicare reductions.

Cuts in Medicare, Medicaid and other health programs have contributed almost $15 billion towards deficit reduction over this same period. Older Americans have borne the burden of reductions in benefits: the Medicare hospital deductible, physician deductible, and premiums have all been increased. The net effect of these increases and spiraling health care costs has meant that in the preceeding five years, the hospital deductible has doubled; the physician deductible almost doubled; coinsurance for physician care doubled and excess charges from physicians tripled.

Over the period 1982-1985, social security and other income security programs suffered combined reductions of $11.4 billion. In fact, as a result of the Social Security Amendments of 1983, and legislated reduuctions in 1981, social security benefits will have been cut $100 billion between 1982-89.

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700

Vita R. Ostrander *President* Cyril F. Brickfield *Executive Director*

TABLE I

REDUCTIONS IN FEDERAL SPENDING FOR THE AGED: INCOME SECURITY AND HEALTH PROGRAMS

(FISCAL YEARS 1982 - 1985)

	Benefit Reductions (In Billions)				Cumulative Reductions (In Billions)
	1982	1983	1984	1985	1982 - 1985
Social Security (Function 650)	0.3	1.2	3.5	3.7	8.7
Other Income Security (Function 600)	0.5	0.5	0.6	1.2	2.7
VA Compensation and Pensions (Function 700)	*	0.1	0.1	0.1	0.2
Medicare (Function 570)	0.6	2.7	3.9	6.0	13.2
Other Health Programs (Function 550)	0.3	0.4	0.6	0.3	1.6
Totals: '	1.7	4.9	8.7	11.3	26.4

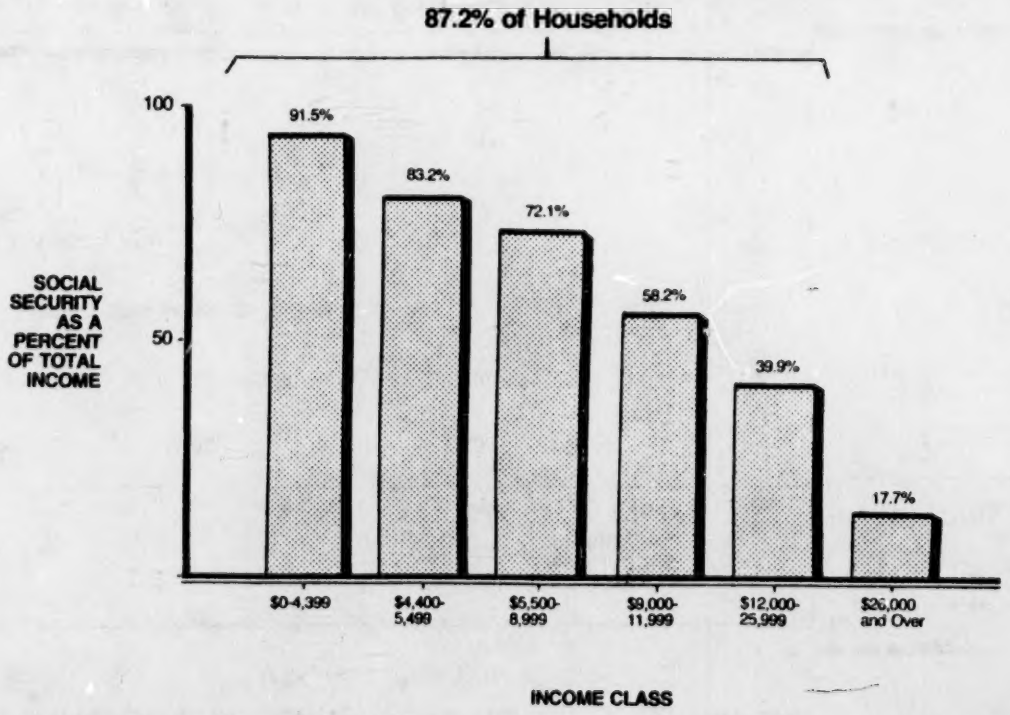
Benefit Reductions and Recovery Resulting from 1983 Social Security Amendments: $66.2 Billion

*Less than $50 million

' Columns do not total due to rounding

Sources: Chamber Associates Incorporated, Office of the Actuary, SSA

SOCIAL SECURITY DEPENDENCY *



* Among Households Age 62 and Over, 1981.

Source: T.C. Borzilleri, 1983; U.S. Census Bureau

Mr. ROBINSON. Thank you.

We will refrain from the questioning until all the panel has completed their testimony.

Mr. ROBINSON. Mrs. Sanchez, you will be the next witness.

For my benefit, and the benefit of the record, would you explain what the El Paso Interreligious Sponsoring Organization is.

Mrs. GIRON-SANCHEZ. That is exactly what I have in my introduction.

Mr. ROBINSON. OK. Fine.

STATEMENT OF MARGARITA GIRON-SANCHEZ, COCHAIR, EL PASO INTERRELIGIOUS SPONSORING ORGANIZATION, ACCOMPANIED BY SISTER BLANDIN MURPHY, EL PASO INTERRELIGIOUS SPONSORING ORGANIZATION, EL PASO, TX

Mrs. GIRON-SANCHEZ. My name is Margarita Giron-Sanchez. I am cochair of the El Paso Interreligious Sponsoring Organization. We are a part of the Industrials Area Foundation, with sister organizations such as Uno of California, Koch of San Antonio, East Brooklyn Churches in New York City, and others.

EPISO is a coalition of churches and civic organizations, primarily Hispanic who have traditionally been left out of the political process.

We represent the poor and the middle class.

One of our primary concerns is indigent health care. We lobbied our State legislators extensively in Austin, TX, to provide moneys for health care.

El Paso is a unique city. We have double digit unemployment. We have many, many elderly. But we also have a young community with many single parents. We have 6,700 public housing with thousands of people eagerly waiting to get in. We have whole neighborhoods who have no drinking water, no electricity, no gas, and some of these communities are worse than what you would find in Mexico.

Last night we had a meeting in one of our neighborhoods. A man told us a horrible story of four children who suffered of dehydration because of the lack of potable water and no electricity. We feel health care is a basic right that all human beings should receive.

This past month my father-in-law suffered a heart attack. He was in intensive care for 3 days, in the hospital for a total of 7 days, and has been under outpatient care since his release.

The cost was outrageous, and we still have not received all the bills.

While he was still in the hospital, in his bed, he received a letter that said that he must pay $400 before he was released.

My father-in-law is 76 years old, receives $442 a month in Social Security. That meant that he was going to have $42 left that month.

My in-laws have turned to us for help, and rightly so. Our culture teaches us that we must take care of our own.

There has to be a safety net where no one falls below. Medicare and Medicaid should be maintained at its highest level possible because those who lose out are the elderly, the poor, and the children.

It is easy to become cold and callous when you do budgets, because all you see is figures, but for every figure you need to see poor, the elderly, and the children.

We urge you to fight for those in need. We have many, many stories that we could talk about today, because we work with the whole city of El Paso.

But to talk a little bit more about her personal experiences, I would like to turn it over to Sister Blandin.

STATEMENT OF SISTER BLANDIN MURPHY, EL PASO INTERRELIGIOUS SPONSORING ORGANIZATION, EL PASO, TX

Sister BLANDIN. Representative Ronald Coleman and gentlemen. My name is Sister Blandin Murphy. I belong to Congregational Sisters. I was past president of the American Association of Retired Persons of the Lower Valley. I work with Our Lady of Mount Carmel Catholic Church. I visit the elderly and families at their homes, and I am an active member of EPISO.

El Paso is a unique city, as you already know. Since you are on the Congressional Border Caucus, we urge you to make known how our city hurts. In my area alone, I hear the cry of the poor daily. I visit the elderly. I hear pathetic problems. Many have to choose between eating and getting medicine; and choose between going to a doctor or paying utilities.

When the poor go to a doctor, their problem has gone beyond control. The doctor's bill is so high. The deductible for Medicare and other expensive tests are prohibitive for persons living on Social Security. The result is the elderly are hostages, held by the U.S. Government, who do not seem to understand the frustration of paying rent, utilities, food, clothing, with a pittance of Social Security for income.

There is another side to this story. Some people say that those receiving Medicare or Social Security can afford cutbacks when they are wealthy. This is not true. Many who are barely hanging on would be priced below poverty level if Social Security, cost of living increases are cut, or they would have to pay higher medical premiums.

It was suggested somewhere that young citizens could take up some of the slack, if cost of living is cut or Medicare copayments rise by supporting an elderly relative.

I think that younger Americans who are hardly making enough for themselves cannot take this responsibility. You must help them. We elderly are not looking for charity. We have contributed all our lives for the money we earned as productive citizens. Now, in our later years, we expect that the promises made by the Government to provide would be fulfilled.

Mr. ROBINSON. Thank you very much.

Our next witness will be Mr. Bill Kennedy.

STATEMENT OF BILL KENNEDY, ADMINISTRATOR, R.E. THOMASON GENERAL HOSPITAL, EL PASO, TX

Mr. KENNEDY. Thank you very much, sir. I would like to, first of all, reiterate a little bit of the summary that is included in my written testimony.

Also, let me say that, as a member of the community, I share a lot of same interests as other people on the panel, and those that have already been spoken to by Mr. Vowell, and by Nancy McDonald.

I would like to address my comments, first of all, from the position of, I think, a professional in the health care community as well as the hospital specific, and what we are looking at with regards to hospital financing.

Mr. COLEMAN. You might give your title, if you would not mind.

Mr. KENNEDY. I am the executive director of the El Paso County hospital district and administrator of R.E. Thomason Hospital.

Mr. COLEMAN. Thank you.

Mr. KENNEDY. First, let me say that Medicare and Medicaid reforms should not be approached with the mere purpose of saving money. The need for the care is there, and it is already established, as you have heard here today. This effort should concern itself with the effectiveness of its dollar, in order to reduce the rate of increase through a more integrated and comprehensive delivery system.

The major areas for consideration when addressing this reform issue can be grouped into two categories, these being hospital specific and what I consider to be program comprehensive.

Hospital specific—let's talk, first of all, severity of illness. The story was told a while ago about the person who had pneumonia and had a cardiac arrest while they were in the hospital.

The current DRG format, as we know it, does not allow for consideration for the degree of illness of a particular patient. It is important to remember that the DRG mechanism was never created to be a reimbursement mechanism; it was created to be a disease classification system. Therefore, consideration should be given to those providers with this fact in mind, that this is the utilization of resources, which has been previously ignored up to this point in time.

Treatment of teaching costs in a situation of R.E. Thomason Hospital and the situation of a lot of teaching hospitals across the country. We serve a large share of the elderly and the underinsured and the poor.

In El Paso County and our companion hospitals throughout the State, probably carry something in the neighborhood of 70 percent of that underinsured charity care load.

Being a teaching hospital, we have a lot of costs associated with that, but at the same time we also provide a service to those indigents and to those underinsured people, which we think would have much more difficulty accessing the health care system if it were not for our types of institutions.

The third item under hospital specific is what I consider to be inconsistent program requirements. Eligibility criteria, reimbursement mechanisms, and audit requirements are just three major differences between Medicare and Medicaid Programs. Although each program has its strong points and its weaknesses, a successful effort to combine these requirements can only result in savings for both hospitals and for the Government and for better treatment of beneficiaries of those programs.

The other category of program comprehensive has four major parts: first of all, access to health care.

One of the major concerns that cannot be overlooked is the potential for limiting the access to health care for the elderly. Let us not forget that Medicare was designed to expand access and health care to the elderly, and was extremely successful in that regard. Now, limiting reimbursement, it does reduce costs, but we need to be certain that we do not deny access that will eventually cause a larger resource drain in the end.

The treatment of the episode of care. This is specific to the DRG. But, first of all, the current reimbursement system focuses upon an acute instance of care. Health care dollars, I feel, could be more prudently spent by considering the entire episode of care to include the input into the system and appropriate patient distribution and maintenance following discharge.

I heard Mr. Vowell speak of the Respite Care Program, and some of the other programs that are more appropriate than hospital care or nursing home care. These types of things, I think, would be much better utilization of our resource dollar.

Maximization of the health care dollar—as referenced earlier, the multiplicity of eligibility requirements, reporting requirements, reimbursement mechanisms, and monitoring criteria create burdensome requirements for both health care facilities and the Government.

Although Medicaid is a Federal program, the implementation varies from State to State throughout the country.

Surely there could be substantial savings for both sides in consolidating many of these functions.

The fourth item is physician participation in PPS. The major purchaser of the health care dollar is the physician. He has control over the admission and the utilization of services while the patient is in the hospital, and he ultimately accepts responsibility for the treatment provided.

To continue the practice of reimbursing physicians by a different methodology serves to establish a potential conflict within the health care community which may cost hospitals, physicians, and the Government far more than the savings that we are currently seeing.

I have four recommendations, be these very general and very comprehensive.

My first recommendation would be that we adjust the DRG mechanism to allow for severity of illness.

I do not think reimbursement through DRG's is necessarily the No. 1 problem with a current Medicare Program; but I feel like that this adjustment of the DRG would allow hospital providers and health care providers a much more fair and much more objective way to look at the resource dollars that are being expended.

Second, I think that we should combine the data requirements among the Federal programs.

I agree with Mr. Vowell. I think we could do a much better job in Texas than is done at the Federal Government level.

But either direction, I think that there could be great savings and efficiencies borne and a lot less problems on the beneficiaries of those programs if they were indeed combined.

Third, treat an episode of care and not just the acute circumstance, which I have already explained.

And, fourth, to include physician reimbursement under PPS.

There are several different approaches to physician reimbursement, and I am not necesarily a proponent of any one of those; but I think that it is important that we align the physicians' financial incentive along with the hospital and health care provider and the health care facility incentives.

Also, extemporaneously, I would like to talk to three other issues.

First of all, from the hospital specific standpoint, from the Thomason General Hospital standpoint, about 60 percent of our operating expenditure comes from money that we generate through patient revenues.

About the same time, 40 percent of our services are provided through ad valorem taxes in the county. It is fair to say—it is appropriate to say that any reduction in that funding, that 60 percent would result in one of two things: Either we reduce the service from our standpoint, or our having to look to the county taxpayer to help assist further in their obligations to delivery health care.

Medicare/Medicaid represents about 17 percent of our gross patient billings. However, that 17 percent translates to somewhere in the neighborhood of 60 or 65 percent of the actual revenue that the hospital operates on.

So, you can see from our standpoint and our ability to deliver care in the community, Medicare and Medicaid funds provide very important resource base to us.

With regard to access, we may as well acknowledge the fact that health care in the United States is a major business; and major businesses do not run and do not continue if they give away their services for free.

I think that any type of Medicare and Medicaid reforms has to look at that very specific title to make sure that a business, be it a public hospital or be it a private hospital is being reimbursed for a fair share of the actual operational costs that are being borne by that hospital in treating one of that program's beneficiaries.

One of the questions that I was asked to address was that of early discharge from hospitals and the type of pressures that are on hospitals and physicians to get Medicare and Medicaid patients out earlier, because of the new DRG requirements.

First, let me say that in the majority of the hospitals, I would imagine that what we see under DRG's is merely an enhancement of the old utilization review techniques.

But I have to say that we have gotten much better at it. We have gotten much more efficient at it, in reviewing actual care that has been delivered in hospitals.

Here again, the decision to discharge is a medical decision borne by the physician. At our particular hospital, we make physicians aware of the information, and we make physicians aware of financial circumstances, but that is a medical decision to be borne by them.

I am more concerned about physicians in the hospitals being put into a situation where they are faced with mounting litigation, and they are faced with potential conflict among themselves.

I am concerned about the effect that that is going to have on the health care community and the delivery system.

At the same time that very concern goes down to the beneficiaries of those programs and the treatment which they received, and, if nothing more, the perception of their presence in the very hospital—why they are there and whether or not their treatment is appropriate.

I think a realigning of those incentives between the hospitals and the physicians and the programs and the beneficiary, I think, are going to be necessary for the Medicare/Medicaid reforms to be both effective and widely accepted.

Thank you.

Mr. ROBINSON. Thank you.

Mr. COLEMAN. Thank you.

[The prepared statement of Mr. Kennedy follows:]

PREPARED STATEMENT OF BILL KENNEDY, ADMINISTRATOR, R.E. THOMASON GENERAL HOSPITAL, EL PASO, TX

Members of the Committee, Medicare and Medicaid reform should not be approached with the purpose of saving money. The need for care is there and already established. This effort should concern itself with the effectiveness of its dollar in order to reduce the rate of increase through a more integrated and comprehensive approach.

SUMMARY

The major areas for consideration when addressing Medicare/Medicaid reforms can be grouped into two categories—hospital specific and program comprehensive.

Hospital specific

1. Severity of illness.—The current DRG format does not allow for consideration for the degree of illness of the patient. It is important to remember that the DRG mechanism was not established initially as a reimbursement mechanism; therefore, consideration should be given to providers for this important factor in resource utilization that has been previously ignored.

2. Treatment of teaching costs.—Many teaching hospitals such as Thomas General provide a disproportionate share of their services to the underinsured and the elderly. It is imperative that fair and appropriate consideration be given to the educational costs, both direct and indirect, to insure the adequate funding of these programs.

3. Inconsistent program requirements.—Eligibility criteria, reimbursement mechanism and audit requirements, are just three of the major differences between the Medicare and Medicaid programs. Although each program has its strong and weak points, a successful effort to combine these requirements could only result in savings for both hospitals and the government.

Comprehensive

1. Access to health care.—One of the major concerns that cannot be overlooked is the potential for limiting the access to health care for the elderly. Let us not forget that Medicare was designed to expand that access and was extremely successful in that regard. Limiting reimbursement does reduce costs, but we need to be certain we are not denying access that will eventually cause an even larger resource drain.

2. Episode of care.—The current reimbursement system focuses upon an acute instance of care. Health care dollars could be more prudently spend by considering the entire episode of care to include input into the system an appropriate patient distribution and maintenance following discharge from the hospital.

3. Maximization of each health care dollar.—As referenced earlier, the multiplicity of eligibility requirements, reporting requirements, reimbursement mechanisms, and monitoring criteria create burdensome requirements for both health care facilities and the government. Although Medicaid is a federal program, the implementation varies from state to state throughout the country. Surely there could be substantial savings for both sides in consolidating many of these functions.

4. Physician participation in PPS.—The major purchaser of the health care dollar is the physician. He has control over admission and utilization of services and accepts responsibility for the treatment provided.

To continue the practice of reimbursing physicians by a different methodology serves to establish potential conflict within healthcare community that may cost hospitals, physicians, and the government for more than the savings that are currently being produced.

RECOMMENDATIONS

1. Adjust DRGs to allow for severity of illness.
2. Combine data requirements among federal programs.
3. Treat an episode of care and not just the acute circumstance.
4. Include physician reimbursement under PPS.

In view of the perceived significant impact on Thomason General Hospital, I would like to expand briefly on two of the aforementioned items.

ACCESS TO NURSING HOME CARE

R.E. Thomason General Hospital has, for many years, been a chief source of health care for the residents of El Paso County. As a public general hospital created by state statute in 1959 and given a source of funding through hospital district property taxes, the 282-bed acute care hospital is charged with the responsibility for providing medical care to the residents of El Paso County. As a major provider for health care in El Paso County, Thomason is reimbursed for services rendered to patients through Medicare, Medicaid, ad valorem taxes, private insurance, and self payment.

The Hospital has been affiliated with the Texas Tech University School of Medicine (TTUSM) since 1973 and serves as the primary teaching Hospital for TTUSM's Regional Academic Health Center in El Paso.

As a major provider for health care in El Paso County, care rendered to Thomason's patients is often dependent upon services provided by other institutions, such as nursing home care. Nursing homes throughout El Paso have played an important role in providing for the continuity of care needed by many of Thomason's patients. However, comprehensive integration of acute care and chronic care services to provide an effective and efficient health care delivery system does not exist in El Paso. This lack of a comprehensive initiative is due primarily to a shortage of Skilled Nursing Beds in the El Paso area.

Nursing homes currently are reimbursed on a cost-basis subject to limits. The cost reports required for payment are burdensome and discourage many low-volume nursing homes from accepting Medicare patients. The vast majority of certified skilled nursing facilities (SNF) provide very few Medicare patient days.[1] Additionally, many investor-owned nursing home systems are moving away from Medicare and Medicaid patients and moving to private pay patients.[2] Many investor-owned chains are waking up to the fact that Medicare and Medicaid will always be "susceptible" to political whims and budget restrictions. No longer will Medicare and Medicaid provide the steady revenue bases of the past.

Thomason has experienced difficulty in placing those patients needing skilled nursing care. If nursing home providers refuse to take Medicare patients, hospitals could face a backlog of patients who are in need of extended care. Hospitals nationwide already have had trouble placing Medicare patients in nursing homes. Nursing home facilities are unwilling to take low Medicare payment for patients who generally require extensive medical care.[3]

Without the ability to appropriately place patients needing skilled nursing care, many acute care facilities will be "caught" pouring resources into custodial care for those patients. In Thomason's case, tax dollars are spent on these patients in an acute hospital environment when extended care is more appropriate and economical.

With the Federal Government looking to cut healthcare funding, any type of reimbursement reform should consider the impact of large cuts in nursing home payments. The government can't cut nursing home payments by large amounts without endangering its efforts to shorten Medicare patients' length of stay in hospitals.[2] If payments to nursing homes are cut too much, nursing homes may stop accepting Medicare and Medicaid patients, and the patient will end up in acute care facilities.

Footnotes at end of article.

Reimbursement reform should enhance the development of a more effective and efficient long-term care delivery system by encouraging integration of actute and chronic care services.[4]

PHYSICIAN REIMBURSEMENT

In FY 1984, Medicare spending for physicians' services was 14.9 billion or $511 per enrollee. Spending for physicians' services is the second largest component (after hospitals) of total Medicare outlays, and in FY 1984 accounted for 24.5 percent of program expenditures. As central decision makers in the health care system, physicians influence over 70 percent of all health care spending.[5] The physicians' impact on program spending therefore extends beyond the reimbursements they receive themselves.

Medicare expenditures for physicians' services is projected to grow at annual rates in excess of 11 percent between FY 1986 and 1990.[5] The expected increase in the supply of physicians may spur competition, slowing the rate of growth in program spending. However, because the physician is the "primary consumer" in the health care system and can generate demand for their services and receive payment through open-ended reimbursement systems, the supply increase may result in higher utilization of health care services.

The Medicare physician payment system has achieved the primary goal of the program—to provide beneficiaries with access to quality health care services. At present, over 29 million beneficiaries are covered by the program and most physicians treat some Medicare patients. However, the Medicare physician reimbursement system has not escaped criticism with regard to both payment and participation policies.

The existing Medicare payment system is confusing for both beneficiaries and physicians. Many times, neither knows how much Medicare will pay until the carrier actually pays the bill. In addition, Medicare's physician payment system is inflationary in terms of both the price and quantity of service. The Medicare payment system maintains the relative price patterns that exist in the market for physicians' services. These patterns represent what some believe to be payment imbalances, given actual resource costs.[5] For example, they tend to favor specialists over generalists; urban areas over rural areas; inpatient treatment over ambulatory care; and diagnostic, laboratory, radiology, and surgical procedures over primary care.[6]

The Medicare participation physician system does reduce beneficiary confusion with regard to which physicians always accept assignment. However, for those nonparticipating physicians, beneficiaries may still not understand why physicians accept assignment for some patients or services but not for others. Physician acceptance of assignment varies in several areas, resulting in variable Medicare financial protection for beneficiaries. In FY 1984, assignment was accept on 56.7 percent of claims, but the rates varied across states from a low 23 percent in South Dakota to a high of 86 percent in Rhode Island.[5]

An inpatient physician PPS using diagnosis related groups (DRGs) would set prospective payments for the package of physicians' services associated with each of the 467 hospital DRGs. The purpose of an inpatient physician DRG system would be to give the physician incentives to practice efficiently and to eliminate marginal procedures. If physicians could not bill for amounts in excess of the package price, they would be at risk for the costs of services provided to treat a case and, therefore, would have direct financial incentives to coordinate the physician resources used within the patient stay. This aligning of reimbursement incentives for physicians and hospitals would lead to efficiencies in the provision of services.

Inpatient physician DRGs could make Medicare spending for inpatient physicians' services more predictable, and provide a way to achieve savings by limiting the rate of increase in package prices. With regards to payment in an inpatient physician DRG system, the attending physician could receive payment and would assume responsibility for the case, obtain services from other physicians as needed, pay those physicians, and hear the financial risk for the costs of the case.

An inpatient DRG system could be structured either to allow or not allow physicians to bill patients for amounts in excess of the package price. If assignment were made mandatory with no extra billing, physicians would have incentives to provide services efficiently and beneficiaries would have strong financial protection. This approach would parallel the mandatory assignment policy for hospitals under PPS.

The inefficiencies in the existing Medicare physician payment and participation system coupled with their impact on the federal budget deficit should make physician Medicare reform a top priority.

BIBLIOGRAPHY

[1] "Long Term Care Briefs," Modern Healthcare, vol. 15, No. 13, June 21, 1985, p. 40.

[2] Punch, Linda, "Investor-owned chains lead increase in beds," Modern Healthcare, vol. 15, No. 12, June 7, 1985, pp. 126, 128, 130, 132, 134, 136.

[3] Fackelmaun, Kathy, "New HCFA regulations could put chill on skilled nursing, home healthcare," Modern Healthcare, vol. 15, No. 9, March 29, 1985, pp. 80, 84.

[4] "Long Term Care for the Elderly," Journal of the American Geriatric Society, vol. 32, No. 10, Oct. 1984, pp 700–704.

[5] Burney, Ira, et. al., "Medicare Physician Payment, Participation, and Reform," Health Aff., vol. 3, No. 4, Winter, 1984, pp. 5–24.

[6] Hsiao, William C., and Stason, W.B., Toward Developing a Relative Value Scale for Medical and Surgical Services," Health Care Financial Review, Fall, 1979.

Mr. COLEMAN. Mr. Chairman, I would want to thank everyone who came to participate today because I think it is important that we begin to discuss the problems.

I am interested in terms of one of the statements that Ms. Bogas made, I think it is very important to make certain that there was no misunderstanding that—of course, Medicare does not cover long-term care.

We think that sometimes many people misunderstand that. I did not want anyone here to leave with any misunderstanding of that kind.

I was wondering, Ms. Bogas, if you would provide for the record later rather than at a public testimony, but I was very interested in terms of what your out-of-pocket hospital bills are in your situation. You might want to accumulate those, add those up, and send them along to me personally or to the committee, because I am concerned with the rising Medicare deductibles and copayments, and what effect that is having.

I think if we can use specific cases and actual facts then——

Ms. BOGAS. I will get you specifics.

Mr. COLEMAN. Well, thank you very much, Ms. Bogas, I appreciate that.

I would like to also, for Mrs. Giron-Sanchez, if she would, to give us maybe some of her experience in terms of working in the community, and I am very interested in knowing what the impact is of the reduction that we see in terms of social programs and monetary capability for delivery of those social programs, for the elderly.

And I was wondering if you could describe a difference that you have seen before and after those reductions, if any; and what your views are with respect to it.

Mrs. GIRON-SANCHEZ. Well, some of the ones that we have been able to witness is not only with the elderly but the young children. Specifically, with those who are entering school at, let's say, 4 year olds, like the Head Start Program.

A lot of those children have never been to a doctor; the families have never been to a doctor; so that means that their costs are going to be a lot higher.

The elderly are very close to our hearts because we have seen many, many people that we are working with, especially with the housing projects, that have not gone to see the doctor because they do not have—well, they have to decide whether they are going to buy food or pay medical bills.

Some of them have had to buy a lot of medication, and I know of one instance where one lady did spend close to $400 within a 2-month period.

So that puts a big burden—and I think they have to make a decision whether they do eat or go to the doctor.

Mr. COLEMAN. Mr. Danley, I would like to ask you specifically—you mentioned those problems with the DRG, and we have had some recent Senate hearings in the Congress with respect to that, and I think the quote that was given as a result of those hearings was that patients are being released "sooner and sicker."

Hospital stays have been reduced, they say, overall from 9 to 7 days, and I was wondering whether you can give us your views about what changes could be made. I would also like to ask the entire panel.

It seems to me that what we are really asking—and I would like your specific thoughts on the matter—is, Where do we go from here?

When we talk about making changes, do we continue to make small changes as we go along, to try to keep up with what we know is a severe chronic national problem in terms of health care, or do we talk about painting with a broad brush and a bold stroke some new system entirely?

I ask the question because there are between 20 and 30 million American people who have no health insurance. There are another 20 million or so who are underinsured. That results from many people having too little money to afford insurance even if it were available. The problem is access to health care since most of the uninsured—and underinsured—do not have access to reasonably-priced health insurance.

So, the question is: Who takes the responsibility? Is it, indeed, the Federal Government?

I have learned something from past elections nationally. I hope we all have. I think that we have got to be forthright with the American people and ask the right questions.

Whose responsibility is it? Is it the employer? the States? the Federal Government? Some combination of those with insurance companies?

I think it is right that we ask the questions, and I would hope that in alluding to the problems that we are talking about that you would feel free to comment on that subject. I think it is very important, and I did ask you——

Mr. DANLEY. Could I just briefly——

Mr. COLEMAN. Yes, sir, Mr. Danley, I did ask you.

Mr. DANLEY. I think the intent of DRG is fine. I know the intent, and it was to curtail runaway charges, and that is great.

I think the only corrective action would be when it becomes necessary to switch to Medicaid; do it on the basis of monthly income rather than wiping out the savings unless they have a lot of savings, but people who have a lot of savings are going to have a good monthly income because they are getting interest.

I think that is the practical approach, but I would not recommend doing away with DRG. I think the intent is great.

Mr. COLEMAN. I agree.

Mr. DANLEY. But the peer review operation is another thing.

Mr. COLEMAN. Anyone else? I hope you will think along those lines with me for just a minute.

I will yield back to you, Mr. Chairman, if you have questions.

Mr. ROBINSON. I would like to also make the point that we would welcome any written testimony that you might have or you might think of, that you can leave or forward it to Congressman Coleman's office, and we will make sure it is added to the record.

I would like to ask each of you collectively to think about this. You might want to respond in writing to Congressman Coleman.

One of the basic problems I see with Medicare down the road is—and I know we are having big problems with it now in that by some projections, by the year 1990, it will be $300 billion in the red.

Aside from the financial burden that it seems to cause all of us, in my opinion in many years, we need to increase the benefits that one receives in Medicare.

For example, long-term care. To the dismay of many, Medicare does not cover long-term care and nursing facilities. Many of our workers work all their life, and they think when they retire something happens then that Medicare will come in and pay for that, and we know—and you talk about those that have saved all of their lives, and it either does one or two things—it turns people into law violators in that they will circumvent the law by giving their money away, and then calling upon Medicaid to pay for it.

I would like each of you to think about it. Should we expand the benefits at a time that we are trying to save money or salvage the system, for example, into long-term care, prescription drugs, preventive health services, eyeglasses, dental care, and the like, along those lines?

I would like to ask you to be honest with us. We would have to pay for that through additional revenues. And my point is, where do we get the money? Cigarette excise tax? minimum corporate tax? payroll tax? general revenues? premiums? whatever?

And I would like you to think about that. No. 1, should we—we know we must salvage the Medicare system. I know that. You know that in good conscience. I could not look you in the eye and tell you that Ron and I would not work to do that.

But also I think we need to look at the long term. We need to increase the benefits in many areas, and also we need to come up with a way to shore up the funding of Medicare. So, I would just like to close by thanking you, each of you, and asking you to please submit any comments that you might have to Congressman Coleman.

Thank you.

Mr. COLEMAN. Thank you.

Thank you, Mr. Kennedy. I appreciate it, Mrs. Bogas. Thank you all for being here. I am very appreciative of that.

The next witness will be Mary Polk, and while she is coming forward, I would like to remind those of you in the audience that at the conclusion of her testimony, we will allow any of you that would like to make a statement to come forward to the mike.

I would just ask you to do it in a orderly fashion. It will be part of the record.

At this time, we will hear from Mary Polk.

STATEMENT OF MARY POLK, EXECUTIVE ASSISTANT, TEXAS DEPARTMENT OF HUMAN RESOURCES

Ms. POLK. Thank you.

I am Mary Polk, executive assistant to the Commissioner of the Department of Human Resources, and the Chairman of our Board does send his regrets. He had planned to be here, but he could not do that. So, I have substituted for him.

Mr. COLEMAN. I would like to comment for the record and for the Committee also, Mr. Livingston Kosberg was scheduled at our original hearing that we had to move to this point in time, and I will say, though that I think compared to Livingston Kosberg we are much more fortunate in having a former colleague in the State Legislature, Mary Polk with us.

Mr. ROBINSON. You may continue.

Ms. POLK. Thank you for the opportunity to testify on an issue that could adversely affect the lives of thousands of disadvantages Texas citizens. Let me assure you, gentlemen, a decrease in Medicaid funding would do just that. And Texans would be one of the great losers.

Impoverished residents of those other southern states that have also shared our conservative approach—and I believe Arkansas is one of those states—that has shared our conservative approach to health care services would also be penalized. However, because of several significant factors, Texans stand to lose more than others.

First, we are the third most populous State, yet we account for a very small percentage of Federal Medicaid expenditures. In fact, only 3.9 percent in fiscal year 1985, compared to a whopping 18.3 percent for New York. Incidentally, our population is expanding at a rate considerably above the national average, and we are projected to surpass New York in total population before the end of the decade.

Those segments of the Texas population that are most likely to qualify for Medicaid services—the children and the elderly—are growing at a phenomenal rate.

In fact, Texans age 75 and older grew almost 44 percent from 1970 until 1980. During this decade, projections indicate that the State's elderly population, age 65 and older, will increase by almost 38 percent.

A decrease in funding that does not take into consideration population changes would certainly unfairly penalize this state and other rapidly growing states.

To further impact the issue, Texas has a larger poverty population than most other states. Yet, we serve a smaller percentage of the needy. Next year, an estimated 3 million Texans—18 percent of the total population—will live below poverty. More than two thirds will either be young, elderly, or disabled. The majority of them will not receive Medicaid in this State.

Our Medicaid Program only serves about 25 percent of those living below the poverty level. The national average is 54 percent, and some States provide services to a far greater percentage. In California, for example, 97 percent of those living below poverty receive Medicaid benefits.

An arbitrarily imposed freeze on Federal Medicaid funds would, in effect, reward those States that have been very "big spenders," and at the same time penalize States like Texas that have contained costs and restricted program growth.

This year, the Texas Department of Human Resources expects to spend about $1.5 billion on Medicaid. The State of New York will spend about $8.1 billion.

What is even more astounding is that in Texas, title 19 Medicaid dollars account for the majority of all Federal funding we receive. That is about 67 percent.

Texas is already suffering from a continuing decline in Federal participation. The Federal Medicaid match for fiscal year 1985 is at 54 percent compared to 63 percent just 10 years ago.

When you compare the Federal taxes paid in Texas to Federal grants received, Texas is the biggest loser. In fiscal year 1984, Texans paid $1.61 in taxes for every Federal dollar that we received. This is the third year that we have had that dubious honor.

In 1981, more than 61 percent of the department budget was federal dollars. That is expected to decrease to about 54 percent in 1986. The Medicaid Program, like many other social services, is a heavy drain on an already strained State budget.

Within the past year our department has made significant progress in extending health coverages for needy Texans. In October, we added Medicaid coverage for certain pregnant women and children in two-parent households. Then, in January, a "medically needy" program was added to further expand services. It is estimated that an additional 25,000 children and pregnant women will be served this fiscal year.

As a State, we are finally becoming less restrictive in health care benefits, but we are doing it in a businesslike manner, by developing cost-effective and efficient service. We have been able to expand our coverage and still contain costs. We are still far from extravagant, though.

Texas actually ranks 45th nationally in per capita Federal Medicaid expenditures. In 1983 New York, once again, spent more than $3.5 billion on medically needy program alone; Texas spent nothing. Then, that same year, New York spent about $481 million in Medicaid funds for mental health patients; Texas spent nothing.

It is also conceivable that a cap would require us to change our State's income eligibility requirements, and thus we would serve fewer people.

Congress has apparently seen the folly of such a move, and early last month with the strong support of our own good Texas Congressional delegation strongly defeated a proposed Medicaid cap. But the budget battle is far from over. It is imperative that we continue with our efforts to inform our lawmakers and their constituents of the folly of such a move. There are far easier ways to contain costs than imposing a Federal Medicaid cap. States should be given incentives to contain medical costs through a wide variety of efforts that best fit their individual programs.

I am speaking from experience when I say that administrative cost containment measures work. As Representative Vowell stated, in 1981, our Department's health care costs increased by 14 per-

cent, and through innovative initiatives, we reduced those increases to about 4 percent last year.

We saved about $34 million in Medicaid-related services through the use of third-party resources. Through our "recipient lock-in" program, we saved an additional $4 million. By establishing a minimum allowable cost for drugs and promoting the use of generic drugs, we expect to save about $4 million this year.

These are just a few examples of how States can save money. The options are many. By allowing States to develop their own cost containment procedures, Congress can reduce Federal Medicaid expenditures while maintaining needed services. It is essential that regardless of their State of residence that the poor be guaranteed a basic level of protection.

Mr. ROBINSON. Thank you.

[The prepared statement of Ms. Polk follows:]

PREPARED STATEMENT OF MARY POLK, EXECUTIVE ASSISTANT, TEXAS DEPARTMENT OF HUMAN RESOURCES

Thank you for the opportunity to testify on an issue that could adversely affect the lives of thousands of disadvantaged Texas citizens. Let me assure you, gentleman, the proposed "cap" on Medicaid spending would do just that. And Texans would not be the only ones to suffer.

Impoverished residents of those other southern states that share our traditionally conservative approach to health care services would also be penalized. However, because of several significant factors, Texans stand to lose more than most.

First and foremost, we are already the third most populous state, yet we account for an almost paltry percentage of federal Medicaid expenditures—3.9 percent in FY 1985, compared to a whopping 18.3 percent for New York. Incidentally, our population is expanding at a rate considerably above the national average, and we are projected to surpass New York in total population before the end of the decade.

Those segments of the Texas population that are most likely to qualify for Medicaid services—the children and the elderly—are growing at a phenomenal rate.

In fact, Texans age 75 and older grew nearly 44 percent from 1970 to 1980. Texans between the ages of 65 and 75 and the adult disabled population have increased almost as rapidly. During this decade, projections indicate that the state's elderly population aged 65 and older will increase by almost 38 percent.

A "cap" that doesn't take population changes into account would unfairly penalize rapidly growing states like Texas.

To further impact the issue, Texas has a larger poverty population than most other states, yet we serve a smaller percentage of the needy. Next year, an estimated three million Texans—18 percent of the total population—will live below poverty. More than two-thirds will be either young, elderly, or disabled. The majority of them will not receive Medicaid benefits.

Our Medicaid program only serves about 25 percent of those living below the poverty level. The national average is 54 percent and some states provide services to a far greater percentage. In California, for example, 97 percent of those living below poverty receive Medicaid benefits. In New York, it's 79 percent, and in Pennsylvania—68 percent.

An arbitrarily impose freeze on federal Medicaid funds would in effect reward those states that have historically been "big spenders," and at the same time penalize states like Texas that have contained cost and restricted program growth.

This year, the Texas Department of Human Resources expects to spend about $1.5 billion on Medicaid services. The state of New York will spend about $8.1 billion.

What's even more astounding is that in Texas, Title 19 Medicaid dollars account for the majority of all funding that comes from the federal government—about 67 percent. A cap on Medicaid would freeze up our largest federal funding source and severely restrict our efforts to provide health care services to the needy.

Texas is already suffering from the continuing decline in federal participation. The federal Medicaid match for FY 1985 is at 54 percent compared to 63 percent ten years ago. Unfortunately, this kind of cutback in federal participation is not unique to the Medicaid program.

When you compare the states' tax burdens to federal grants and aid received, Texas is the biggest loser. In FFY 1984, Texans paid $1.61 in taxes for every federal dollar received. This is the third year that we have had that dubious honor.

In FY 1981, more than 61 percent of the department budget was federal dollars. That's expected to decrease to about 54 percent in FY 1986. The Medicaid program, like so many other social services, is a heavy burden to an already strained state budget. Fortunately, our elected officials recognize the critical need for such programs and support our efforts to provide them.

Our board's recent efforts to expand coverage to additional needy populations had the backing of both state and federal lawmakers. Congress lifted restrictions on state Medicaid spending, and state legislators authorized the funds.

As a result, within the past year our department has made significant progress in extending health coverage for needy Texans. In October, we added Medicaid coverage to certain pregnant women and children in two-parent households. Then, in January a "medically needy" program was added to further extend services by raising the program's income limits. Through these efforts we expect to serve an additional 25,000 pregnant women and children this fiscal year.

As a state, we are finally becoming less restrictive in our health care benefits, but we are doing it in businesslike manner. By developing cost-effective and efficient service delivery systems, we have been able to expand coverage and still contain costs. We are still far from extravagant in our services, and we have a lot of catching up to do.

Texas ranks 45th nationally in per capita federal Medicaid expenditures. Our $48.80 per person expenditure is significantly lower than the $82.76 national average.

In FFY 1983, New York spent more than $3.5 billion on the medically needy program alone. Texas spent nothing. That same year, New York spent more than $481 million in Medicaid funds for mental health patients. Texas spent nothing.

In fact, of the 10 most populous states, Texas is the only one without Medicaid coverage for the mentally ill. We are now studying the possibilities of extending coverage to that population. A federal cap on Medicaid would not only eliminate that option, but it would also jeopardize the few optional services that we recently added. The cap would, in effect, lock in past inequities.

It is also conceivable that a cap could require us to change the state's income eligibility requirements and thus serve fewer needy people.

Right now, more than 43 percent of the elderly Texans live below the proverty level. Less than one-third receive Medicaid services. Only those who meet the resource requirements and have a monthly income of about $631 qualify. When you consider that the maximum allowable is about $984, you realize how conservative Texas has been.

Our intention is to raise the monthly income cap to about $670 so more of the state's low-income elderly will qualify. Our state Legislature has approved raising the income eligibility cap, but has not included additional funding for the resulting increased caseload. A freeze on federal matching funds would force us to retain existing eligibility requirements or possibly even lower the maximum monthly income allowed.

Congress has apparently seen the folly of such a move and early this month soundly defeated the proposed cap on Medicaid spending. The strong support from the Texas congressional delegation was crucial.

But the budget battle is far from over. It is imperative that we continue with our efforts to inform our lawmakers and their constituents of the folly of such a move. There are far better ways to contain costs than by imposing a federal Medicaid cap.

States should be given incentives to contain medical costs through a wide variety of efforts that best fit their individual programs. I'm speaking from experience when I say administrative cost-containment measures work. In 1981, our department's health care cost increases exceeded 14 percent. Through innovative initiatives, we reduced increases to approximately 4 percent last year.

We saved the state nearly $34 million in Medicaid-related services through the use of third-party resources. Through our recipient "lock-in" program, we saved an additional $4 million. By establishing a maximum allowable cost for drugs and promoting the use of generic drugs, we expect to save more than $4 million.

These are just a few examples of recent cost savings. If given greater flexibility in other areas, states could further reduce health care costs.

By taking advantage of changes in the delivery of medical services and restructuring optional programs that become cost prohibitive, states could cut spending. Other possibilities include implementing co-pay options and limiting a patient's freedom of choice in obtaining certain health services.

The options are many. By allowing states to develop their own cost-containment procedures, Congress can reduce federal Medicaid expenditures while maintaining needed services. It is essential that, regardless of their state of residence, the poor be guaranteed a basic level of protection.

Thank you.

Mr. ROBINSON. Mr. Coleman.

Mr. COLEMAN. Thank you.

I understand that the Health and Human Services Department has given our State, Texas, a Medicaid waiver. It allows Texas to expand the home health care program instead of having to place the elderly in nursing homes.

I was wondering if you could give me, or give us some of your input about how that demonstration project is working, or has worked.

Ms. POLK. Well, I think, Congressman Coleman, if you will remember when you were in the Legislature, we did away with level 2 of care, and we grandfathered those level 2—we got a waiver to grandfather those level 2 people that ran nursing homes into the nursing home, so that we could determine the people that could actually stay at home and receive that home care.

That has worked very well in this State. We have kept our nursing home population down; we have increased the number of those people that received the home health services, and what the waiver that you just mentioned would do would allow us to do that even more, to increase that more because we believe that those people that are able to stay at home can better be taken care of by giving them some home services that they need.

And those then that do need the nursing home can be put in the nursing home.

I guess one thing that has bothered us—we are about to lose that waiver that allowed us to grandfather in the level 2 care people and even though they have been in the nursing home, I suppose it has been about 12 years now, I think, and they are still at level 2 eligibility determination; and those will all have to be paid for with State money unless we can address that in some other way.

Mr. COLEMAN. That is an issue that I am sure that Nancy McDonald is totally aware of. We had an interesting meeting earlier this year in Austin on the health care subject, and I hope that the three of us—Jack, the four of us, can continue to communicate on this issue because I think it is wrong.

As you pointed out, when the Medicaid cut—when the cap was proposed, all it did was punish the States that were doing the best job of administering the health care programs.

For heaven's sakes, we will have incentives for that, not punishment for it, and so I appreciate your remarks, and I appreciate your testifying today.

Thank you, Mr. Chairman.

Mr. ROBINSON. Thank you. This concludes the portion of our hearing in which we have had various individuals testify—three panels.

At this point in the hearing, any person wishing to make a comment or a statement, please come forward to the mike.

Mr. COLEMAN. Let me just say anybody, anybody can make a statement. The reason we did not just get up and end the hearing

right now was so that if any of you did have any comments or statements that you would like to put into the record you could feel free to come up to the microphone and make any statements.

If you think that we have not covered all the subjects, you are right. We know in the timeframe we had allotted and because of airline schedules and other things, for members of the committee, we could not get everything said and done; but I hope that all of you will feel absolutely free to send comments to me in writing.

I will make sure they are part of the record, if you do not care to make a statement today. Maybe we have in your own mind generated some new ideas, some thoughts, something maybe you had forgotten that has been a problem with you or your family, your parents, or your children. I would hope that if you would let us know those things. We need to make sure that the committee has input from our community.

The statistics that were presented by our State legislators and those who have testified, I think, are very dramatic, and very telling.

And so, I hope that if you have those comments and do not care to make them here today, that you will certainly send them along to me or my staff, or drop them by the office right down here at the Federal Building, or the Federal Courthouse, where my office is on the first floor.

I would like to thank all of you that have come, and extend special thanks to Tommy Robinson, as well as Mike Synar, and let them know how much we appreciate their coming out here in the friendly city of El Paso.

Mr. ROBINSON. Thank you. If there is no further business, this concludes the hearing by the Select Committee on Aging.

Thank you for attending.

Mr. COLEMAN. Thank you.

[Whereupon, at 4:24 p.m., the hearing was adjourned.]

APPENDIX

AARP,
El Paso, TX, July 3, 1985.

Subject: House Select Committee on Aging, Medicare/Medicaid Hearings.

Hon. RONALD COLEMAN,
U.S. Representative, Texas, Washington, DC.

MY DEAR CONGRESSMAN: This is in response to your invitation to attendees at the July 2 El Paso hearing to file statements.

I would like to direct the Committee's attention to an important aspect of Medicare reform introduced at the hearing by my AARP colleague, Jack Danley. This is his finding that "reasonable cost" determinations under Part B vary throughout the 50 states, as does the formula on which such determinations are made by the carrier in each state, although premiums paid by Part B beneficiaries are uniform nationwide. Furthermore, these "reasonable costs" are not known in advance by either the doctor or the patient so that serious financial shocks to either the assignment-accepting physician and/or the patient can be suffered.

In addition to the obvious unfairness and inequity of this situation, the accessibility and affordability of health care, which is the subject of the Committee's attention, is affected. Those older people in the lower half of what we might call the middle income brackets cannot afford to cover these potentially large "Medigaps" through private insurance and are thus forced to live in jeopardy of having their retirement income and life savings wiped out. It is proper to show priority concern for those in poverty, but we should not continue policies which penalize the larger numbers of our citizens who are fortunate or wise enough not to be in poverty yet.

I stress this because I think Mr. Danley may be the only witness anywhere who brings this problem to the Committee's attention and I think it is of national importance. In addition, I wish to say that we of AARP in El Paso fully endorse and support the other recommendations being made to the Committee by our AARP officials in Washington.

Regards,

JACK H. SMITH.

EL PASO, TX, *July 3, 1985.*

Hon. RONALD COLEMAN,
U.S. Representative, Texas, Washington, DC.

DEAR CONGRESSMAN COLEMAN: I thought you would be interested in my syndicated column in connection with your interests in Social Security and your work with the House Select Committee on Aging.

No doubt you are familiar with the legislation introduced by Rep. Pickle and I have a hunch you support it.

Cordially,

JACK SMITH.

[From the El Paso Times, July 3, 1985]

SOCIAL SECURITY SYSTEM WORTH SAVING

(By Jack Smith)

Probably nothing is more a flag-waving cause for older Americans than the Social Security system.

Thus, on Independence Day 1985, it seems appropriate to consider protecting Social Security from the political fireworks that have been threatening its stability.

Those of us who began playing in the system close to a half-century ago may remember it was then managed by a bipartisan board reporting directly to the president. Social Security was a separate entity, not a subdivision of a huge federal agency (today known as the Department of Health and Human Services) where it is subject to cost duplications, unwieldy clearances and political hassles. It was not part of the unified budget and thus did not loom as an inviting target for deficit reduction.

Wilbur J. Cohen, the first employee of the Social Security board in 1935, is today working zealously from his "retirement" post as professor in the Lyndon B. Johnson School of Public Affairs at the University of Texas at Austin to get contributory social insurance back in this distinctive and independent position. As he puts it, "taking the football away from the politicians."

He supports HR 285, introduced by U.S. Reps. Jack Pickle, D-Austin, Daniel Rostenkowski, D-Ill., Edward Roybal, D-Calif., and Bill Archer (R-Houston)—and cosponsored by about 80 other congressmen—to put the running of Social Security under a board patterned on the original model.

Cohen also endorses a recent recommendation to House Ways and Means by friend and former Commissioner Robert M. Ball that Social Security be separated from the unified budget now—not waiting for 1992, as called for in the 1983 amendments to the Social Security Act.

"It is doubtful that we would be discussing (today) Social Security cuts on the context of deficit reduction if it were not for the inclusion of Social Security in the unified budget," Ball testified.

I agree. I see no reason why long waiting time must be worked into so many things that the Congress decides to be good policy for older Americans. Some whose support is being counted will not be able to enjoy the benefiots.

"Today Social Security is adequately financed in both short and long term," Ball told the committee.

"Yet, as long as the program remains in the unified budget, there will be a temptation to cut benefits to make the overall deficit appear smaller. The result is that trust fund surpluses are built even more rapidly with the money being lent to the government at interest . . (This) does not reduce the overall debt of the U.S.; rather, it changes the ownership of that debt, in part, from private owners to the Social Security funds."

Confidence of younger people in the system is important to older people, Cohen said, because the younger people are making the current financial contributions to the system. This confidence is hardly helped when the news is full of debate about the long-range solvency and the level of future benefits each time a new federal budget is proposed.

He co-chairs the Save Our Security Coalition (SOS), whose headquarters are at 1201 16th St., Washington, D.C. 20036, and has both individual and group members who make voluntary contributions to carry on the effort. You might celebrate an oldtimers' Fourth of July by shooting notes to your representative and senators in Washington urging restoration of the (1) independent board and (2) independent budget soonest.

O